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Supreme Court, U.S.
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In The

Supreme Court of the United States

ROSS GLENN MOORMAN, JR.,

Petitioner,

v.

UNUMPROVIDENT CORPORATION,
UNUM LIFE INSURANCE COMPANY OF AMERICA,
and UNUM CORPORATION,

Respondents.

On Petition For Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

RHONDA MICHELE MOORMAN, M.D., J.D.
Counsel of Record

MEDLAW, INC.
Post Office Box 2437
Douglas, Georgia 31534-2437
Telephone: 229-446-4565 / 888-800-2462
Facsimile: 888-832-5460
E-mail: rmoorman@medlawinc.com

Attorney for Petitioner
Ross Glenn Moorman, Jr.

COCKLE LAW BRIEF PRINTING CO (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1) In evaluating Moorman's ERISA claims against Unum, a conflicted plan administrator, the District Court granted summary judgment through *de novo* review. In keeping with its *de novo* review, the District Court refused to consider Moorman's credible evidence outside of the administrative record that Unum acted out of bias. While Moorman's appeal was pending, this Court established as the appropriate standard in such cases the arbitrary and capricious standard with consideration of outside evidence of administrator bias, and explicitly rejected the application of *de novo* review, in *Metropolitan Life Ins. Co. v. Glenn,* 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008). Having been alerted to *Glenn*, did the Court of Appeals err in refusing to apply *Glenn* or remand the case to the District Court for that purpose?

2) In *Humana, Inc. v. Forsyth,* 525 U.S. 299, 119 S.Ct. 710 (1999), this Court recognized that an individual insurance policyholder's claim under federal RICO "advances the State's interest in combating insurance fraud". 525 U.S. at 314, 119 S.Ct. at 765. More recently in *Glenn*, this Court held that in evaluating an ERISA policyholder's claim against a conflicted plan administrator, a reviewing court should consider evidence outside of the administrative record of administrator bias. Together, *Humana* and *Glenn* give rise to an important question of first impression nationally that this Court should answer:

QUESTIONS PRESENTED – Continued

Where a plaintiff pursues both an ERISA and a federal RICO claim against a conflicted plan administrator, should the court consider evidence outside of the administrative record of plan administrator bias not only in support of the plaintiff's ERISA claim, but also in support of the plaintiff's federal RICO claim?

3) Together, *Humana* and *Glenn* also give rise to a second important question of first impression nationally that this Court should answer: Where a plaintiff sues under both ERISA and federal RICO, are those distinct federal claims requiring independent consideration by the court at summary judgment? If so, is it impermissible for the court to rely upon the narrow evidentiary limitations of ERISA to preclude consideration of the plaintiff's federal RICO claim?

PARTIES TO THE PROCEEDING

Petitioner (Plaintiff and Appellant below):

ROSS GLENN MOORMAN, JR.

Represented by
Rhonda Michele Moorman, M.D., J.D.
MEDLAW, INC.
P. O. Box 2437
Douglas, Georgia 31534-2437

Respondents (Defendants and Appellees below):

UNUMPROVIDENT CORPORATION
UNUM LIFE INSURANCE COMPANY
OF AMERICA
UNUM CORPORATION

Represented by
Kenton Jones Coppage, Esq.
Elizabeth Johnson Bondurant, Esq.
Nicole Marie Crow, Esq.
H. Sanders Carter, Jr., Esq.
SMITH MOORE LEATHERWOOD LLP
Atlantic Center Plaza
1180 West Peachtree Street NW
Suite 2300
Atlanta, Georgia 30309-3482

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CITATIONS FOR ORDERS AND OPINIONS BELOW

The order of the Court of Appeals (App. 1-2) affirming the District Court's grant of summary judgment is reported at 303 Fed. Appx. 760, 2008 U.S. App. LEXIS 25402 (11th Cir. Dec. 17, 2008). The orders of the District Court granting summary judgment (App. 5-42), of the District Court denying Moorman's Motion for Leave to File Cross-Motion for Summary Judgment (App. 45-46), and of the Court of Appeals denying Moorman's Petition for Rehearing, Petition for Rehearing En Banc, and Petition for Issuance of Written Opinion (App. 47-48) were not reported.

BASIS FOR JURISDICTION IN THIS COURT

The decision of the United States Court of Appeals for the Eleventh Circuit affirming the decision of the United States District Court for the Northern District of Georgia was issued on December 17, 2008. Moorman timely filed a Petition for Rehearing, Petition for Rehearing En Banc, and Petition for Issuance of Written Opinion on January 6, 2009, which he supplemented on January 22, 2009. The decision of the United States Court of Appeals for the Eleventh Circuit denying Moorman's Petition for Rehearing, Petition for Rehearing En Banc, and Petition for Issuance of Written Opinion was issued on February 13, 2009. This Petition for Writ of Certiorari is filed within ninety (90) days of February 13, 2009. 28

U.S.C. §2101(c). This Court has jurisdiction pursuant to 28 U.S.C. §1254(1).

RELEVANT STATUTORY PROVISIONS

Employee Retirement and Income Security Act of 1974 (ERISA), 29 U.S.C. §1001, *et seq.*

29 U.S.C. §1132:

§1132. Civil enforcement

(a) Persons empowered to bring a civil action. A civil action may be brought –

(1) by a participant or beneficiary –

. . .

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . .

Federal Racketeer Influenced and Corrupt Organizations Act of 1970 (RICO), 18 U.S.C. §1961, *et seq.*

18 U.S.C. §1961:

§1961. Definitions

As used in this chapter –

> (1) "racketeering activity" means . . . (B) any act which is indictable under any of the following provisions of title 18, United States Code: . . . section 1341 (relating to mail fraud), section 1343 (relating to wire fraud) . . .

18 U.S.C. §1341:

§1341. Frauds and swindles

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, . . . for the purpose of executing such scheme or artifice or attempting so to do, places in any post office or authorized depository for mail matter, any matter or thing whatever to be sent or delivered by the Postal Service, or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier, or takes or receives therefrom, any such matter or thing, or knowingly causes to be delivered by mail or such carrier according to the direction thereon, or at the place at which it is directed to be delivered by the person to whom it is addressed, any such matter or thing, shall be fined under this title or imprisoned not more than 20 years, or both.

18 U.S.C. §1343:

§1343. Fraud by wire, radio, or television

Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication in interstate or foreign commerce, any writings, signs, signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall be fined under this title or imprisoned not more than 20 years, or both.

18 U.S.C. §1962:

§1962. Prohibited activities

(c) It shall be unlawful for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern or racketeering activity or collection of unlawful debt.

(d) It shall be unlawful for any person to conspire to violate any of the provisions of subsection (a), (b), or (c) of this section.

18 U.S.C. §1964:

§1964. Civil remedies

> (c) Any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefore in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee . . .

STATEMENT OF THE CASE[1]

Factual Background

The Plan

This lawsuit arises out of Unum's denial of Moorman's claim for long-term disability benefits. The relevant plan provides long-term benefits if the policyholder becomes "unable to safely and completely perform 2 activities of daily living without another person's assistance or verbal cueing" or becomes "cognitively impaired." "Activities of daily living" (ADLs) include "[t]oileting – getting to and from and on and off the toilet, maintaining a reasonable level of personal hygiene, and caring for clothing" and "[c]ontinence – voluntarily controlling bowel and

[1] Where appropriate, Moorman provides citations to the record below.

bladder function; or in the event of incontinence, maintaining a reasonable level of personal hygiene." (App. 6-8) (AR 250).[2]

Claim for Benefits

On February 15, 1999, at the age of fifty-eight (58), Moorman was diagnosed with a locally advanced adenocarcinoma of the rectum. (AR 377). Moorman underwent preoperative chemotherapy and radiation therapy, surgery to create a permanent colostomy, and eight months of postoperative chemotherapy, for a total of twelve months of aggressive therapy. (AR 188).

Moorman submitted his claim for benefits on March 7, 1999. (AR 379, 53). Unum obtained an unrestricted release for Moorman's medical records (AR 91) and contact information for Moorman's six treating physicians – one radiation oncologist, two medical oncologists, one surgeon, one gastroenterologist, and one primary care physician. (AR 379, 377, 151, 143,

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[2] The administrative record admitted to the lower Courts and used throughout this litigation is a copy that Unum produced in discovery. In so doing, Unum Bates stamped the administrative record in reverse, or descending chronological, order. As a result, page ranges referenced in the following discussion are likewise provided in reverse, or descending chronological, order. Unum also included in the administrative record multiple copies of some documents. Accordingly, some citations to the administrative record in the following discussion refer to multiple copies of the same document as those appear in the administrative record.

53). Unum informed Moorman that if it needed medical records or information from him, it would obtain them or let him know. (AR 54, 83). Unum paid Moorman short-term disability benefits for thirteen weeks, then approved Moorman's long-term disability benefits. (AR 331-330, 5-4). Shortly after Moorman filed his claim, Unum contacted Moorman's radiation oncologist and requested Moorman's medical records, which he provided. (AR 368-360, 142-135, 42-34). Five months later, Moorman's primary care physician completed a medical supplemental statement attesting to Moorman's significant disability. (AR 152-148, 103-99).

That statement was the last medical record that Unum obtained prior to terminating Moorman's benefits over eight months later. Throughout those eight months, Moorman informed Unum that he was undergoing colostomy surgery and postoperative chemotherapy. (AR 368-360, 142-135, 42-34, 150, 101, 86, 59, 46, 25). Moorman also regularly provided updated contact information for his treating physicians. (AR 95, 111). Despite this, Unum never requested Moorman's medical records – from Moorman's treating physicians or Moorman himself. (Boothby Depo. at 113:9-114:1, 122:13-123:2; Luedtke Depo. at 208:3-209:1; 209:8-13; Beecher Depo. at 107:22-108:12). Likewise, Unum never informed Moorman that it did not have those records. (Boothby Depo. at 113:9-114:1, 122:13-123:2; Luedtke Depo. at 80:18-22).

Unum sent Moorman a brochure describing Unum's Work Incentive Benefit Provision. (Complaint at Exhibit 11 p. 8; Moorman Depo. at Defendant's Exhibit 1 p. 8; Boothby Depo. at 30:12-20, 31:10-15, 31:24-32:4 and Exhibit 5 p. 8 and Exhibit 6). Unum represented to Moorman that he qualified for that program, which would allow Moorman to return to work part-time with no reduction in benefits. (Complaint at Exhibit 11 p. 8; Moorman Depo. at Defendant's Exhibit 1 p. 8). Representatives of Unum confirmed this in numerous telephone conversations with Moorman's Office Manager, and provided explicit instructions for not exceeding the allowable salary and wages under the provision. (Moorman Depo. at 54:12-57:17 and Defendant's Exhibit 2). Relying upon Unum's representations (Moorman Depo. at 87:19-88:4, 118:3-119:8), Moorman, a small business owner, returned to work part-time. (AR 111; Moorman Depo. at 47:3-7). At the time, Moorman was still sick and undergoing chemotherapy. (Moorman Depo. at 47:3-7).

Shortly thereafter, Unum transferred Moorman's claim from Unum's Atlanta, Georgia office to Unum's Chattanooga, Tennessee headquarters. (AR 109-107). Immediately after the transfer, Unum informed Moorman that contrary to its previous representations, Moorman was not entitled to Work Incentive Benefits. (AR 116-114, 119-117; Boothby Depo. at 39:15-41:8 and Exhibit 10). Unum demanded that Moorman return an alleged overpayment of $4,873.76, warning that if he failed to do so, his benefits would

be terminated. (AR 115, 118; Boothby Depo. at 40:20-41:8 and Exhibit 10).

Relying upon Unum's earlier representations, Moorman did not return the alleged overpayment, but rather informed Unum that he felt as though he had been misled. (AR 115-114; Boothby Depo. at 43:18-21 and Exhibit 10). Thereafter, Unum terminated Moorman's benefits. (AR 155-153, 130-128). Unum later informed Moorman that he in fact *was* entitled to Work Incentive Benefits, and paid Moorman the benefits that it had wrongfully withheld. (AR 127-126). However, Unum refused to reinstate Moorman's benefits. (AR 127-126; Boothby Depo. at 80:24-81:1 and Exhibit 19).

Unum's decisionmaker in terminating Moorman's benefits was Adam Douglas Boothby. (Boothby Depo. at 14:25-15:5). Mr. Boothby based his termination of Moorman's benefits largely upon the fact that Moorman had returned to work part-time (AR 154, 131, 129) – despite knowing that Moorman had returned to work at Unum's urging, based upon Unum's representations that his return to work would not affect his benefits, and while sick and undergoing chemotherapy. (AR 116-114; Boothby Depo. at 40:8-12 and Exhibit 10). At deposition, Mr. Boothby testified that he: (1) was newly hired at the time that he terminated Moorman's benefits (Boothby Depo. at 14:11); (2) has no medical education or training (Boothby Depo. at 105:20-22); (3) is unable to read or interpret any of Moorman's medical records that were before him at the time that he terminated Moorman's

benefits (Boothby Depo. at 101:6-10 and Exhibit 25, 110:20-113:8, 115:11-122:10, 126:19-127:19); (4) knows nothing about Moorman's disability (Boothby Depo. at 107:12-108:4) or even what part of the body it involves (Boothby Depo. at 116:13-23); and (5) knows nothing about the treatment Moorman received or its side effects. (Boothby Depo. at 105:23-108:12, 114:5-12).

Mr. Boothby further testified that at the time that he terminated Moorman's benefits, he: (1) had contact information for Moorman's treating physicians (Boothby Depo. at 35:10-12; AR 379, 377-376, 368, 150, 143, 142, 111, 95, 51-50); (2) had a full release for Moorman's medical records (AR 91); and (3) had in Moorman's claim file numerous notations of Unum's own agents that Unum needed to contact Moorman's treating physicians for updated medical records. (AR 326, 325, 46, 25). Nonetheless, Mr. Boothby: (1) did not contact any of Moorman's physicians (Boothby Depo. at 113:9-114:1 and 122:13-123:2) or otherwise obtain any medical information or assistance (Boothby Depo. at 113:9-114:12 and 114:2-12 and 122:22-123:2); (2) never asked Moorman to contact his physicians or provide updated medical records (Boothby Depo. at 113:9-114:1 and 122:13-123:2); and (3) never requested that Moorman undergo an independent medical examination (IME) or interview with Unum as provided for in the plan (Boothby Depo. at 114:2-4; AR 249).

Administrative Appeal

On August 2, 2000, Moorman's then-attorney, Mr. Curtis Farrar, submitted a letter of appeal to Unum. (AR 158-157, 134-132). From the time of Moorman's appeal on August 2, 2000 until March 7, 2001 – over seven months – Unum sent Moorman monthly self-described "delay letters" that failed to explain the reason for Unum's delay in deciding his appeal – none of which were signed by the ostensible author. (AR 161, 162, 167, 169, 175, 186; *see also*, R11-127-Attachment 4 at pp. 40-49 and ¶¶117-150). Although each letter represented that Moorman's appeal was under review, in fact Moorman's appeal was neither assigned to, nor being considered by, any agent of Unum for much of that time. (*See id.*) Finally, almost eight months after Mr. Farrar submitted Moorman's appeal, Unum informed Moorman that his appeal had been denied. (AR 199-197, 192-190). As of the denial of Moorman's appeal, Unum had never asked Moorman for any medical records or other information. (*See generally,* AR).

Moorman's appeal was denied by Unum employee Kari Lynne Luedtke. (Luedtke Depo. at 245:2-5). Ms. Luedtke forwarded Moorman's appeal to Unum's Medical Review Department (AR 179, 185-183), where it was assigned to Unum's in-house oncology nurse, Jan Oliver (AR 185). Ms. Oliver concluded that Moorman's medical file was incomplete, and that updated medical records would be required in order to evaluate the appeal. (AR 185-184).

Instead of obtaining Moorman's updated medical records as Ms. Oliver suggested, Ms. Luedtke forwarded Moorman's appeal to Unum's in-house physician, Nancy Burt Beecher, M.D. (AR 183). At her deposition, Dr. Beecher testified that she: (1) did not complete any medical residency (Beecher Depo. at 17:19 and 19:15-20:6); (2) at the time, had not examined or treated patients for approximately ten years (*Id.* at 55:4-10); (3) has never treated a patient for cancer (*Id.* at 53:17-54:9); (4) knows nothing about the treatment that Moorman received (*Id.* at 69:3-15, 79:2-4, 80:12-81:25, 85:20-86:1, 96:15-97:10, 100:25-101:10, 172:2-4, 173:3-7, 181:12-15, 216:2-6); (5) has never provided colostomy care (*Id.* at 176:22-24); and (6) knows nothing about a colostomy, its daily care, how a colostomate toilets, or how those issues lead to workplace disability. (*Id.* at 161:1-162:20, 180:2-21, 185:14-19).

Though Moorman informed Unum that he had lost the ADLs of toileting and continence (AR 158-157, 134-132), Dr. Beecher in her report did not address either toileting or continence, and she made no findings regarding whether Moorman had suffered the loss of those particular ADLs. (AR 183; Beecher Depo. at 167:4-13; Luedtke Depo. at 118:21-119:9). Dr. Beecher testified at deposition that she was influenced by the fact that Moorman had returned to work part-time, believing that "says something, that he's not seriously impaired, you know." (Beecher Depo. at 88:8-10). Unum did not inform Dr. Beecher that Moorman had returned to work at the express

invitation of Unum, though sick and undergoing chemotherapy. (Beecher Depo. at 88:15-19:22).

While Dr. Beecher was reviewing Moorman's file, and in response to Ms. Luedtke's request (AR 163-166, 168, 170-172), Ms. Luedtke received a letter from Moorman's primary care physician, Gary Newcomer, M.D., attesting to Moorman's disability. (AR 188-187). Though Dr. Beecher had not yet rendered her opinion, Ms. Luedtke did not bring Dr. Newcomer's letter to Dr. Beecher's attention, with the result that Dr. Beecher never considered it. (App. 15-16, 24-25 n.13; Beecher Depo. at 117:15-19; Luedtke Depo. at 169:9-13). Nor did Ms. Luedtke consider it in denying Moorman's appeal. (AR 198, 191). At her deposition, Dr. Beecher testified that, having reviewed Dr. Newcomer's letter in preparation for and at her deposition, she is now of the opinion that "[i]t raises several issues, issues that would need to be resolved one way or another" prior to deciding the appeal. (Beecher Depo. at 107:22-108:12). Dr. Beecher further testified that those issues could have been resolved with objective evidence, such as with updated medical records or an IME. (*Id.* at 107:22-108:12, 109:2-110:1, 118:1-18, 110:6-14, 205:1-24). Finally, Dr. Beecher testified that had she seen Dr. Newcomer's letter, she "might have said we just – we've got to have those records. We can't do anything without the records . . . " (*Id.* at 107:22-108:12).

Both Ms. Luedtke and Dr. Beecher testified that in asking her to review Moorman's appeal, Ms. Luedtke, knowing Moorman's medical file to be incomplete, nonetheless asked Dr. Beecher that

specific question: Whether Moorman's medical file was complete. (Beecher Depo. at 110:15-112:1; Luedtke Depo. at 101:25-102:4, 107:5-7, 203:18-23). When Dr. Beecher responded that Moorman's medical file was not complete, without making any determination of disability (*Id.; see also,* Beecher Depo. at 85:20-86:1, 96:15-97:10, 172:2-4, 173:3-7, 181:12-15), Ms. Luedtke used that negative response to deny the appeal. Both Ms. Luedtke and Dr. Beecher testified that that was both Ms. Luedtke's usual practice and what happened in this case. (Luedtke Depo. at 111:5-113:4; Beecher Depo. at 134:16-20).

Ms. Luedtke testified that she: (1) was hired by Unum approximately two months after Moorman filed his appeal, and Moorman's appeal was one of the first that she handled (Luedtke Depo. at 21:19-20, 33:9-20); (2) has a high school diploma (*Id.* at 16:20-24); (3) has no academic or professional degrees (*Id.*); (4) has no education or training in medicine (*Id.* at 16:25-17:9, 18:11-19:10); (5) cannot read or interpret a medical record (*Id.* at 98:2-15); (6) cannot read or interpret Moorman's medical records that were before her at the time that she decided Moorman's appeal (*Id.* at 238:4-240:7 and Exhibit 40); (7) does not know the difference between a primary care physician and an oncologist or surgeon (*Id.*); (8) does not know what type of physician Moorman would have seen for his cancer care (*Id.*); (9) knows nothing about Moorman's diagnosis, treatment, or treatment side effects (*Id.* at 126:15-129:12, 136:18-139:4, 139:5-141:19); (10) knows nothing about a colostomy, its care, toileting as a colostomate, or resulting workplace disability (*Id.* at

229:22-232:4); and (11) knows nothing about Moorman's level of disability. (*Id.*)

At the time that she denied Moorman's appeal, Ms. Luedtke had contact information for Moorman's treating physicians (Luedtke Depo. at 210:5-13; AR 379, 377-376, 188, 150, 143, 142-135, 111, 95, 92, 53-51). For reasons that she is unable to explain, and despite Dr. Beecher's and Ms. Oliver's clear instructions to obtain updated medical records, Ms. Luedtke did not contact any of Moorman's treating oncologists or surgeon. (Luedtke Depo. at 208:3-209:1, 209:8-13). She furthermore ignored letters from Moorman's primary care physician and attorney as well as Moorman's own representations of disability. (AR 199-197, 192-190).

Ms. Luedtke at her deposition expressly admitted that, having reviewed Moorman's claim file in preparation for and at her deposition, she is now of the opinion that she should have obtained Moorman's updated medical records from his treating oncologists and surgeon, and that such information "would have been helpful" in determining Moorman's appeal. (Luedtke Depo. at 227:12-228:5, 228:17-229:3).

Procedural History

Moorman filed his Complaint on July 16, 2004. Therein, Moorman asserts claims pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. §1001, *et seq.*, and the Federal Racketeer Influenced Corrupt Organizations Act of 1970 (RICO), 18 U.S.C. §1961, *et seq.* While Moorman

originally asserted claims under Georgia state law, the District Court dismissed Moorman's state law claims as preempted by ERISA. On March 4, 2008, the District Court granted summary judgment on all claims to Unum (App. 42), and issued judgment with costs against Moorman. (App. 43-44).

Moorman appealed to the Court of Appeals for the Eleventh Circuit. Following oral argument on December 5, 2008, the Court of Appeals on December 17, 2008 affirmed the decision of the District Court. (App. 1-2). Moorman filed his Petition for Rehearing or Rehearing En Banc, which he later supplemented. The Court of Appeals denied Moorman's Petition for Rehearing or Rehearing En Banc on February 13, 2009. (App. 47-48).

REASONS FOR GRANTING CERTIORARI

I. The District Court granted summary judgment based upon a standard of review that was subsequently rejected by this Court in *Glenn*, and the Court of Appeals erred in refusing to either apply *Glenn* or remand the case to the District Court for that purpose.

In granting summary judgment, the District Court applied a *de novo* standard of review that this Court subsequently rejected in *Metropolitan Life Ins. Co. v. Glenn,* 128 S.Ct. 2343, 171 L.Ed.2d 299 (2008). (App. 5-42). The Court of Appeals without explanation refused to either apply *Glenn* or remand

the case to the District Court for that purpose. (App. 1-2).

A. Development of this Court's Current Standard of Review

1. *Firestone*

In *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), this Court held that "a denial of benefits . . . is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator . . . authority to determine eligibility for benefits or to construe the terms of the plan", in which case a deferential standard of review is appropriate. *Id.* at 115. This Court continued: "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting *Restatement (Second) of Trusts* §187, Comment d (1959)).

2. *Glenn*

Three months after the District Court's decision, this Court revisited *Firestone* in *Glenn.* Picking up where *Firestone* left off, this Court in *Glenn* identified factors giving rise to a conflict of interest and provided specific guidance regarding how the court should consider conflict of interest. This Court confirmed its holding in *Firestone* that where a plan administrator both evaluates claims and pays benefits, that plan

administrator has a conflict of interest that the court must consider. 128 S.Ct. at 2348. This Court further held that in the case of a plan administrator who both decides and pays claims, that particular

> conflict of interest . . . should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.

Id. at 2351.

This Court in *Glenn* explicitly rejected the notion that conflict of interest changes the standard "from deferential to *de novo* review." *Id.* at 2350. Rather, this Court stressed the fact that arbitrary and capricious remains the appropriate standard, even where there is conflict of interest. *Id.* However, under *Glenn*, where there is conflict of interest, the court is required to consider evidence outside of the administrative record indicating possible administrator bias. *Id.* at 2351.

In addition, this Court in *Glenn* held that a reviewing court should give conflict of interest great weight where the evidence shows that the plan administrator encouraged the policyholder to engage in certain behaviors for the administrator's financial benefit, then later reversed course – again, for the administrator's financial gain. *Id.* at 2352. Subsequent circuit courts have followed suit. *See, e.g.*,

Hackett v. Standard Ins. Co., 559 F.3d 825, 2009 U.S. App. LEXIS 5823 at *14 (8th Cir. March 19, 2009). In both *Glenn* and *Hackett*, the plan administrator encouraged the claimant to apply for social security disability benefits. In subsequently determining the claimant's eligibility for continued benefits, the administrator disregarded the Social Security Administration's finding that the claimant was disabled. Here, Unum encouraged Moorman to return to work part-time, while sick and undergoing chemotherapy, upon the promise of continued benefits, then abruptly terminated Moorman's benefits on the grounds that he had returned to work.

Glenn's clarification of *Firestone* is crucial to this case. Unum admits, and the District Court agreed, that as both plan administrator and payor of benefits, Unum operates under a conflict of interest. (App. 19).

B. The District Court applied a *de novo* standard of review explicitly rejected by this Court in *Glenn*.

1. The District Court's *Williams/Wise de novo* Standard of Review

In response to *Firestone* and before *Glenn*, courts devised various methods of accounting for administrator conflict of interest. In the Eleventh Circuit, the resulting test was articulated in *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132 (11th Cir. 2004). Under *Williams*, the court was required to conduct the following six-step analysis: (1) Under

de novo review, is the plan administrator's decision "wrong?" If not, end the inquiry and grant summary judgment to the administrator. (2) If the decision is *de novo* "wrong," is the administrator "vested with discretion in reviewing claims"? "[I]f not, end the judicial inquiry and reverse the decision." (3) If the administrator's decision is wrong and he is vested with discretion, is the decision reasonable under an arbitrary and capricious review? (4) If the decision is unreasonable, end the inquiry and reverse the decision. If reasonable, determine if the administrator "operated under a conflict of interest." (5) If not, end the inquiry and affirm the decision. (6) If there is a conflict of interest, apply a "heightened arbitrary and capricious" review. *Id.* at 1138.

In *Burt v. Metropolitan Life Ins. Co.*, 2005 WL 4712457, 2005 U.S. Dist. LEXIS 22810 (N.D. Ga. 2005) (slip op.), this District Court adopted the three-step condensed *Williams* test enumerated in *Wise v. Hartford Life and Accident Ins. Co.*, 360 F.Supp.2d 1310 (N.D. Ga. 2005): (1) Under *de novo* review, is the administrator's decision "wrong"? "If not, the administrator prevails." (2) If the decision is *de novo* wrong, is it "reasonable"? If the decision is "both wrong and unreasonable (*i.e.* arbitrary and capricious), then the claimant is entitled to prevail." (3) Where the decision is wrong but reasonable, the court must apply a "heightened arbitrary and capricious review, which is something more exacting than arbitrary and capricious review, but more deferential than *de novo* review." *Burt,* 2005 WL 4712457 at *7, 2005 U.S. Dist. LEXIS 22810 at *20-22 (citing *Wise,* 360

F.Supp.2d at 1318; also citing *HCA Health Services, Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 994-95 (11th Cir. 2001)).

According to the District Court, pursuant to the *Williams/Wise* standard of review, "'[r]eview is confined to the evidence that was before the administrator when the claim for benefits was denied.'" (App. 20) (quoting *Richards v. Hartford Life & Accident Ins. Co.*, 153 Fed. Appx. 694, 696 (11th Cir. 2005) (citing *Lee v. Blue Cross/Blue Shield of Ala.*, 10 F.3d 1547, 1550 (11th Cir. 1994)). The District Court stressed that review is limited to the administrative record at both the first step's *de novo* review and the third step's "heightened arbitrary and capricious" review. (App. 25 n.13) (citing *Lee*, 10 F.3d at 1550).

2. The District Court's Application of the *Williams/Wise de novo* Standard of Review to This Case

In granting summary judgment to Unum, the District Court applied the three-step *Williams/Wise* test. (App. 19-20). In so doing, the District Court applied *de novo* review (App. 19-20) and refused to consider evidence outside of the administrative record. (App. 19-20, 25 n.13). The District Court found that Unum made the "correct" decision. (App. 28). The District Court bolstered its position by stating that *even if* Unum's decision were *de novo* wrong, it nonetheless was reasonable under the test's second step. (App. 30, 35). Even while evaluating

Unum's reasonableness, the District Court refused to consider Moorman's outside evidence of plan administrator bias as is now required under *Glenn*. (App. 30-35). Having found in Unum's favor on steps one and two of the *Williams/Wise* test, the District Court declined to proceed to the third step, application of the "heightened arbitrary and capricious review." (App. 35).

This Court in *Glenn* made it clear that the appropriate standard of review is the arbitrary and capricious standard with consideration of outside evidence of bias. The *Williams/Wise* test used by the District Court never allowed Moorman to reach that analysis. Instead, the District Court blocked Moorman at the door with a *de novo* review that precluded consideration of the outside evidence that this Court in *Glenn* found relevant.

Moorman anticipates the argument that since the District Court applied the least deferential *de novo* standard of review, there would be no point in remanding the case for application of *Glenn*'s more deferential arbitrary and capricious standard. However, this position was recently discredited by the Tenth Circuit Court of Appeals in *Brown v. Hartford Life Ins. Co.*, 301 Fed. Appx. 772, 2008 U.S. App. LEXIS 26366 (10th Cir. Dec. 5, 2008). There, the Court held that where the district court's "use of a *de novo* standard of review was . . . legally erroneous," unless the reviewing court can determine "that the denial of benefits was appropriate under the arbitrary and capricious standard," the court "must

reverse and remand for further proceedings," because "in applying the arbitrary and capricious standard an additional factor comes into play: . . . conflict of interest." 301 Fed. Appx. at 775, 2008 U.S. App. LEXIS 26366 at *7-8 (citations and footnote omitted). As in *Brown*, "Because it applied *de novo* review, the district court did not expressly consider this factor." *Id.*

While applying a *de novo* standard of review and limiting its own consideration to the administrative record, the District Court nonetheless criticized Moorman for not providing evidence of disability "even up to th[e] day" of summary judgment. (App. 36). Referencing two letters from Unum to Moorman's attorney after Moorman's claim and appeal had been denied, the District Court found that "Unum sent Mr. Moorman numerous letters inviting him to submit additional evidence and notifying him that Unum had no updated medical records." (App. 42). The Court of Appeals likewise focused upon this point at oral argument. However, both lower Courts ignored Moorman's irrefutable evidence – from within the administrative record – that Unum made both of the two requests *after* Moorman's claim and appeal had been denied. (AR 199-197, 201-200). Unum did so in an attempt to create the very post-appeal defense anticipated by 29 C.F.R. §2560.503.1(c)(3)(i), which establishes that where a plan offers voluntary, post-denial and post-appeal reconsideration, a claimant may not be faulted for choosing not to submit a benefit dispute to those voluntary review processes. *See Halpin v. W.W.*

Grainger, Inc., 962 F.2d 685, 689 (7th Cir. 1992) (lack of "adequate early notice [of claim deficiencies] . . . may not be remedied by the later provision of a full explanation and/or a post-appeal invitation to remedy the defect through the provision of updated medical records").

As Moorman pointed out to both lower Courts, the question is not whether Unum acted reasonably *after* it denied Moorman's claim and appeal. The question is whether Unum acted reasonably *in denying* that claim and appeal. Were the law otherwise, a plan administrator could avoid liability forever by simply offering successive, post-appeal administrative reconsiderations, and the claim and administrative appeal review processes would have no meaning. Moorman reiterated his position in a letter sent to the Court of Appeals immediately after oral argument and in his subsequent Petition for Rehearing, to no avail.

The District Court explicitly noted "that the medical records it must rely on in conducting the *de novo* review are exceptionally sparse". (App. 29 n.15). Indeed, the question before the District Court was not *whether* the medical records were complete, but rather *why* they admittedly were incomplete. Moorman claims that pursuant to its longstanding scheme of wrongfully denying claims, Unum *intentionally* refrained from conducting a reasonable investigation or notifying him that medical records were needed. In refusing to look beyond the administrative record, the District Court effectively deprived

Moorman of that argument – even though all of the relevant evidence was on file with the District Court.

Moorman placed before the District Court evidence that Unum's actions were motivated by bias, and furthermore that they were consistent with the company's longstanding and widely publicized scheme of wrongfully denying claims for the sake of company profits. The District Court, not yet privy to *Glenn* and applying the *Williams/Wise de novo* standard of review, ignored Moorman's evidence, refusing even to mention that evidence in its order. (App. 5-42).

C. The District Court also violated this Court's standard of review for summary judgment as set forth in *Liberty Lobby*.

Federal Rule of Civil Procedure 56(c) provides for summary judgment where "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." "The plaintiff, to survive the defendant's motion, need only present evidence from which a jury might return a verdict in his favor. If he does this, there is a genuine issue of fact that requires a trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249-50, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). In considering a motion for summary judgment, the court must view all evidence in the light most favorable to the nonmoving party, and must resolve all disputes and draw all inferences in the nonmovant's favor. *Id.* at 255. The court may not resolve factual disputes, make credibility determinations, or draw inferences from the facts, as these

responsibilities rest exclusively with the jury as the finder of fact. *Id.*

Moorman presented credible evidence that: (1) at the time Unum denied his claim and appeal, Moorman was disabled under the terms of the plan; (2) in considering Moorman's claim and appeal, Unum refused to obtain Moorman's updated medical records, ask him for his medical records, or notify Moorman that medical records were needed; (3) throughout this time, Unum led Moorman to believe that if it needed anything from Moorman, it would ask him; (4) Unum denied Moorman's claim with no updated medical records, and based upon no medical review whatsoever; (5) Unum denied Moorman's claim not because he was not disabled, but because Moorman had returned to work part time, though sick and undergoing chemotherapy – which Moorman did at the explicit request and encouragement of Unum and based upon Unum's express representations that Moorman's return to work would not affect his benefits; (6) in violation of the applicable regulations, Unum delayed the determination of Moorman's appeal for some eight months; (7) during the eight-month pendency of Moorman's appeal, Unum ignored determinations by its own employees that Moorman's claim file was incomplete and that updated medical records were needed, refused to obtain Moorman's updated medical records or inform Moorman that they were needed, and ignored evidence of disability submitted by Moorman's physician and attorney as well as Moorman himself; and (8) Moorman's claim and appeal decisions were made by biased, unqualified

Unum employees who knew nothing about Moorman's disability and who failed to conduct reasonable investigations.

In support of his federal RICO claim, Moorman presented credible evidence that Unum subjected him to numerous acts of mail and wire fraud through its communications with him regarding the Work Incentive Benefit Provision and Moorman's appeal. All such communications were fraudulent and transmitted in furtherance of Unum's purpose to deprive Moorman of his benefits without fair evaluation.

Moorman furthermore presented credible evidence demonstrating that Unum's established claims handling and appeal processes in actuality were part of a biased, intentional, fraudulent scheme whereby Unum routinely denied the claims of policyholders like Moorman. First, Moorman presented the findings of the Targeted Multistate Market Conduct Examination conducted by the Maine Bureau of Insurance, the United States Department of Labor, and all fifty United States insurance commissioners. That examination concerned Unum's claims handling activities during the very years that Unum denied Moorman's claim and appeal. Investigators ultimately found Unum guilty of the fraudulent conduct of which Moorman complains. Settlement agreements were reached pursuant to which a number of Unum's subsidiaries, including Respondent Unum Life Insurance Company of America, agreed to review past claims, pay fines of $15 million per subsidiary, and be subject to fines of $100,000.00 per day and $145 million. As a

result of required claims reviews, Unum reversed 42 percent of previously denied claims and paid out $676 million in additional benefits.

Second, Moorman presented the deposition testimony of Patrick Fergal McSharry, M.D. and William Edgar Feist, M.D. Dr. McSharry served as medical director at Unum during the years that Moorman's claim and appeal were denied, and he was trained by and worked closely with Dr. Beecher at the time that Dr. Beecher considered Moorman's appeal. Dr. Feist served as medical director for Unum's corporate predecessor, Provident Corporation, currently known as The Unum Group. Both Dr. McSharry and Dr. Feist testified that the biased claims handling and other fraudulent conduct uncovered by the Targeted Multistate Market Conduct Examination – and alleged by Moorman – was widespread and consistent throughout their employment at Unum and Provident Corporation, respectively.

Finally, Moorman directed the District Court's attention to Unum's extensive history of litigation over these very claims.

In granting summary judgment, the District Court ignored Moorman's evidence, weighed the facts, and drew inferences from the facts against Moorman in violation of *Liberty Lobby*. In addition, the District Court reached detailed medical conclusions based upon no medical authority – medical conclusions that even Unum's own medical reviewers could not reach. (App. 24-28) ("Mr. Moorman has not lost the ADL of

continence." (App. 27)). Even in considering the administrative record, the District Court reached conclusions directly contradicted by the administrative record itself – such as that Unum did not know who or where Moorman's treating physicians were, making it reasonable for Unum not to have contacted them – when the administrative record is replete with evidence to the contrary. (AR 379, 377-376, 368-361, 212, 208, 188, 150, 143, 142-135, 111, 95, 92, 53-51).

Moorman submitted credible evidence creating a genuine issue for trial regarding whether Unum's actions were arbitrary and capricious in violation of ERISA, and also regarding whether Unum subjected Moorman to an unlawful scheme using fraudulent mail and wire communications in violation of federal RICO. Under Fed. R. Civ. P. 56(c) and *Liberty Lobby*, the District Court erred in granting summary judgment against him.

D. In affirming the District Court, the Court of Appeals failed to heed this Court's clear directive and created a split among the circuits regarding the proper application of *Glenn* to the actions of a conflicted plan administrator.

Having alerted the Court of Appeals to this Court's decision in *Glenn*, while his Petition for Rehearing was pending, Moorman filed with the Court of Appeals a Notice of Intervening Case Law and Supplement to Petition for Rehearing. Therein,

Moorman alerted the Court of Appeals to the decisions of the Second Circuit Court of Appeals in *McCauley v. First Unum Life Ins. Co.*, 551 F.3d 126 (2nd Cir. Dec. 24, 2008) and the Ninth Circuit Court of Appeals in *Nolan v. Heald College,* 551 F.3d 1148 (9th Cir. Jan. 13, 2009). Those Courts applied *Glenn* to similar facts to rule in favor of the policyholder.

Due to its striking similarities to this case, *McCauley* warrants brief discussion.

1. Second Circuit Court of Appeals: *McCauley v. Unum*

McCauley involved facts and evidence virtually identical to those present here, and was also brought against Unum. As Moorman, McCauley alleged disability resulting from treatment for colon cancer. McCauley's claimed disabilities included bowel incontinence, chronic diarrhea, insomnia, fatigue, and chronic pain requiring the daily use of pain medications – claims virtually identical to Moorman's (except that, as a result of having a permanent colostomy, Moorman arguably is more disabled than McCauley). The similarities do not end there. In considering McCauley's appeal, First Unum refused to consider a letter and memorandum written by McCauley because they lacked a physician's signature. As here, First Unum refused to notify McCauley of its rejection of his proffered evidence until it denied his appeal.

According to the Second Circuit Court of Appeals, "First Unum blithely ignored detailed descriptions

constituting clear proof of total disability". 551 F.3d at 135. The Court continued: "Taken in combination, these factors are plainly exacerbated by First Unum's conflict of interest, as both administrator and payor, for what else would have influenced First Unum to avoid following up on simple inquiries prompted by McCauley's . . . submission?" *Id.* at 136. The Court continued: "Had he been apprised of them, McCauley plainly would have had no trouble addressing First Unum's undisclosed and uninvestigated concerns." *Id.* The Court concluded: "At a minimum, further investigation was required." *Id.*

In this case, Unum had letters from Moorman's primary care physician and attorney and Moorman's own representations of disability. Unum ignored all of this evidence, ostensibly because it was not accompanied by physician office notes. However, despite spending over a year supposedly evaluating Moorman's claim and appeal, Unum never contacted Moorman's treating physicians, requested office notes, or informed Moorman of the situation.

Regarding evidence of plan administrator bias considered by the *McCauley* Court, that too is identical to Moorman's. The Court held:

> First Unum is no stranger to the courts, where its conduct has drawn biting criticism from judges. A district court in Massachusetts wrote that "an examination of cases involving First Unum . . . reveals a disturbing pattern of erroneous and arbitrary benefits

> denials, bad faith contract misinterpretations, and other unscrupulous tactics." *Radford Trust v. First Unum Life Ins. Co., 321 F.Supp.2d 226, 247 (D. Mass. 2004), rev'd on other grounds, 491 F.3d 21, 25 (1st Cir. 2007).* That Court listed more than thirty cases in which First Unum's denials were found to be unlawful, including one decision in which First Unum's behavior was "culpably abusive." *Id. at 247 n.20.* Also, First Unum's unscrupulous tactics have been the subject of news pieces on "60 Minutes" and "Dateline," that included harsh words for the company. *Id. at 248-49.* First Unum has fared no better in legal academia. *See* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA, 101 Nw. U. L. Rev. 1315 (2007). In light of First Unum's well-documented history of abusive tactics, and in the absence of any argument by First Unum showing that it has changed its internal procedures in response, we follow the Supreme Court's instruction and emphasize this factor here. Accordingly, we find First Unum's history of deception and abusive tactics to be additional evidence that it was influenced by its conflict of interest as both plan administrator and payor in denying McCauley's claim for benefits.*

Id. at 137 (emphasis added). The Court concluded that given the above evidence of wrongdoing, "a reasonable trier of fact could only come to one conclusion: First Unum's denial was arbitrary and capricious."

Id. at 138. The Court reversed the district court and granted summary judgment in McCauley's favor. *Id.*

2. Eighth Circuit Court of Appeals: *Chronister v. Unum Life*

Very recently, the Eighth Circuit Court of Appeals applied *Glenn* to the actions of Respondent Unum Life Insurance Company of America and reached the same conclusion. In *Chronister v. Unum Life Ins. Co. of America,* 2009 U.S. App. LEXIS 9033 (8th Cir. April 30, 2009), the Court stated: "The question before the Court is whether *Glenn* changed the way courts should review Unum's decision." *Id.* at *3-4. Answering in the affirmative, the Court explained: "There is no doubt that *Glenn* changed ERISA review in some ways. . . . Under *Glenn*, courts must analyze the facts of the case at issue, taking into consideration not only the conflict of interest, but also other factors that might bear on whether the administrator abused its discretion." *Id.* at *4-5 (quoting *Glenn,* 128 S.Ct. at 2351).

As in *McCauley*, the Court in *Chronister* specifically considered Unum's well-publicized history of wrongful claims denials, and in so doing considered much of the evidence that Moorman placed before the lower Courts here. The Court held:

> Here, there are several factors that point to an abuse of discretion in Unum's handling of Chronister's claim. First is Unum's financial conflict of interest, which during the time of Chronister's initial application for benefits

> led to a "disturbing pattern of erroneous and arbitrary benefit denials, bad faith contract misinterpretations, and other unscrupulous tactics." *Radford Trust v. First Unum Life Ins. Co., 321 F. Supp. 2d 226, 247 (D. Mass. 2006) [rev'd on other grounds, 491 F3d 21, 25 (1st Cir. 2007)].* The Supreme Court itself commented on Unum's "history of biased claims administration." *Glenn, 128 S. Ct. at 2351* (citing John H. Langbein, Essay, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA, 101 Nw. U. L. Rev. 1315, 1317-21 (Spring 2007)).* Unum's history of arbitrarily denying claims such as Chronister's is another factor that the Court must consider in determining whether Unum abused its discretion in denying Chronister's claim. *See Glenn, 128 S. Ct. at 2351* (noting that a conflict of interest should be more important in cases where the insurer has "a history of biased claims administration").

2009 U.S. App. LEXIS 9033 at *7-8. The Court concluded: "Weighing all of the evidence, as *Glenn* requires, the Court is left with the firm impression that Unum's decision to deny Chronister's remanded claim was an abuse of the discretion given to Unum under the terms of the plan." *Id.* at *10. Finding that remand of the matter "would needlessly delay the already long-delayed benefits payments," the Court reversed the judgment of the district court and remanded the matter "for the entry of judgment in Chronister's favor." *Id.* at *10-11.

3. Eighth Circuit Court of Appeals: *Wakkinen v. Unum Life*

The Eighth Circuit Court of Appeals also applied *Glenn* to the actions of Respondent Unum Life Insurance Company of America in *Wakkinen v. Unum Life Ins. Co. of America,* 531 F.3d 575 (8th Cir. 2008):

> Even though no conflict of interest could be assumed *pre-Glenn*, Wakkinen argued in his brief that a palpable conflict exists because UNUM engaged in unlawful procedures in handling his claim. The procedures he refers to are those that were subject to a multistate examination of the claims handling practices of UNUM Life and other subsidiaries of UNUM Provident. These practices are the subject of the law review article [by John H. Langbein] quoted by the Supreme Court in [*Glenn*]. In September 2003, the Department of Labor and state regulators began a joint examination of claim files and claim administration and policy manuals from these companies to determine if their disability income claims handling practices reflected systematic unfair claim settlement practices. The examiners found several areas of concern, including excessive reliance upon in-house medical professionals, unfair construction of attending physician or independent medical exam reports, failure to evaluate the totality of the claimant's medical condition, and inappropriate burdens placed on claimants to justify their eligibility for benefits. The result was a plan of corrective action implemented through a

> regulatory settlement agreement and consent orders entered into with the states.

531 F.3d at 582. Although after considering numerous other factors, the Court concluded that Unum's conflict of interest was not a sufficient "tiebreaker in favor of finding that UNUM abused its discretion," the Court emphasized the importance, under *Glenn*, of that conflict of interest to the analysis. *Id.*

4. Additional Circuit Court Rulings After *Glenn*

Since *Glenn* was decided last summer, numerous circuit courts of appeals have applied *Glenn* to reach results opposite to the Eleventh Circuit Court of Appeals here. *See, e.g., Johnson v. Conn. Gen. Life Ins. Co.,* 2009 U.S. App. LEXIS 7398 at *17-18 (6th Cir. April 7, 2009); *Lafleur v. La. Health Serv. and Indem. Co.,* 2009 U.S. App. LEXIS 6104 at *30 (5th Cir. March 23, 2009); *Delisle v. Sun Life Assurance Co. of Canada,* 558 F.3d 440, 445 (6th Cir. March 4, 2009). Numerous other courts of appeals have remanded cases to the district court for application of *Glenn*. *See, e.g., Vaught v. Scottsdale Healthcare Corp. Health Plan,* 546 F.3d 620, 633 (9th Cir. 2008); *Burke v. Pitney Bowes Inc. Long-Term Disability Plan,* 544 F.3d 1016, 1025 (9th Cir. 2008); *Jones v. Mountaire Corp. Long Term Disability Plan,* 542 F.3d 234, 239 (8th Cir. Sept. 2008); *Sweeney v. Aetna U.S. Healthcare,* 284 Fed. Appx. 207, 2008 U.S. App. LEXIS 14773 (5th Cir. 2008).

While retaining *Firestone*'s deferential standard of review, this Court in *Glenn* nevertheless allowed for a more comprehensive and fair review of the actions of a conflicted plan administrator by making claims history relevant. The Eleventh Circuit Court of Appeals stands alone in refusing to apply *Glenn* in this case. For his part, Moorman is left with the troubling certainty that had he brought his claims in another court, they likely would have survived summary judgment. It is this lack of evenhandedness in the interpretation and application of the law, this inexplicable inequality of outcome, that this Court is charged with rectifying.

5. The Court of Appeals should have issued an opinion explaining its decision.

At both the most recent and the first oral argument in this case, the Court of Appeals entered into spirited discussions with counsel regarding Moorman's ERISA and federal RICO claims. As part of his recent appeal, Moorman alerted the Court to *Glenn*, which fundamentally changes the way courts of the Eleventh Circuit must evaluate ERISA claims against conflicted plan administrators – and which invalidates the District Court's approach. Certainly, the Court of Appeals at the very least should have issued a written opinion setting forth its reasons for affirming the District Court despite *Glenn*. Rather than doing so, the Court simply stated: "After oral argument and a thorough review of the record and

the parties' briefs, we conclude that the district court did not abuse its discretion or commit any reversible error." (App. 2). Though Moorman in his Petition for Rehearing in the alternative requested a written opinion, the Court of Appeals ignored Moorman's request. (App. 47-48).

The Court of Appeals' actions are improper for several reasons. First, they leave Moorman not knowing why, after five years, his claims failed despite the recent successes of others identically situated. Second, they substantially complicate this Petition and proposed appeal given the lack of explanation below. Finally, they leave others with no precedent to guide future conduct and litigation. By refusing to explain its actions, the Court of Appeals "so far departed from the accepted and usual course of judicial proceedings ... as to call for an exercise of this Court's supervisory power." Sup. Ct. R. 10(a).

II. Together, *Humana* and *Glenn* give rise to an important question of first impression nationally that this Court should answer: Where a plaintiff pursues both an ERISA and a federal RICO claim against a conflicted plan administrator, should the court consider evidence outside of the administrative record of plan administrator bias not only in support of the plaintiff's ERISA claim, but also in support of the plaintiff's federal RICO claim?

In *Humana Inc. v. Forsyth*, 525 U.S. 299, 119 S.Ct. 710 (1999), this Court recognized that an

individual policyholder's claim under civil RICO "advances the State's interest in combating insurance fraud", and furthermore that federal RICO complements other civil enforcement schemes (there, Nevada insurance law). 525 U.S. 299 at 313-314. This Court in *Humana* entertained amicus briefs from numerous national groups, including the United States Department of Justice, the National Association of Insurance Commissioners, United Policyholders, The National Fair Housing Alliance, Trial Lawyers for Public Justice, and various insurance receivers. All of those groups supported application of federal RICO to individual policyholder claims such as Moorman's.

In *Glenn*, this Court established that evidence such as Moorman's is relevant to the ERISA inquiry into conflicted plan administrator bias. Moorman now asks this Court to take the next logical step in holding that where an ERISA plaintiff also sues under federal RICO, the court likewise should consider that same evidence in support of the plaintiff's federal RICO claim.

In the instant case, both lower Courts abdicated their decisionmaking responsibility by ignoring the driving force behind this litigation – Moorman's federal RICO claim. The lower Courts' avoidance of the federal RICO question is particularly unfair to Moorman. Over the past five years, those Courts have required Moorman, a disabled individual, to single-handedly build a federal RICO case. This required that Moorman travel around the country taking deposition after deposition of Unum's current and former

employees. After those depositions were properly filed, both lower Courts refused to address Moorman's evidence or substantively consider Moorman's federal RICO claim. (App. 1-2, 5-42, 47-48). It is just this type of judicial waste – allowing matters to survive dismissal and go into expensive discovery, only to dismiss them at summary judgment – that constitutes judicial case mismanagement and creates the appearance of injustice condemned by the Court of Appeals itself in *Chudasama v. Mazda Motor Corp.*, 123 F.3d 1353 (11th Cir. 1997).

III. Together, *Humana* and *Glenn* give rise to a second important question of first impression nationally that this Court should answer: Where a plaintiff sues under both ERISA and federal RICO, are those distinct federal claims requiring independent consideration by the court at summary judgment? If so, is it impermissible for the court to rely upon the narrow evidentiary limitations of ERISA to preclude consideration of the plaintiff's federal RICO claim?

The District Court on two separate occasions ruled that Moorman has a right, as a matter of law, to bring a federal RICO claim in addition to his ERISA claims. In an earlier appeal and following oral argument, the Court of Appeals declined to disturb that ruling. *Moorman v. UnumProvident Corp.*, 464 F.3d 1260, 1273 (11th Cir. 2006). That sent the parties into time-consuming and expensive discovery, and the resulting evidence is voluminous.

As discussed above, the District Court determined, under a pre-*Glenn de novo* review limited to the administrative record, that Unum's claims decisions were "correct." Relying exclusively upon that determination, the District Court concluded that "Unum did not *wrongfully* deny [Moorman's] claim, much less do so fraudulently", with the result that no federal RICO violation could have occurred. (App. 42). The Court of Appeals affirmed the District Court without explanation. (App. 2). Moorman's federal RICO case was thus dismissed without its ever being considered independent of his ERISA claims and the administrative record.

The lower Courts erred in so ruling. Moorman's federal RICO claim stands independent of and distinct from his federal ERISA claims, and thus requires independent consideration at summary judgment. Under any standard of review, consideration of Moorman's federal RICO claim is not limited to the administrative record. As a result, the District Court's making the survival of Moorman's federal RICO claim dependent upon the results of the Court's *de novo* ERISA review was improper. At summary judgment, Moorman had a right to have the voluminous evidence that he presented considered. Indeed, had the District Court in making its ERISA determination considered evidence outside of the administrative record of Unum's bias as is now required under *Glenn*, that same evidence necessarily would have supported Moorman's federal RICO claim, and both claims would have survived summary judgment.

IV. Granting certiorari in this case would allow this Court to consider taking a step beyond *Firestone*, *Humana* and *Glenn*, thus enabling policyholders to aid in the fight against insurance fraud by allowing them to effectively pursue claims under federal RICO.

Thirty-five years ago, Congress passed ERISA in part to encourage the development of employee benefit plans. In accordance with that mission, ERISA provides to plan administrators significant protection from liability for claims denials. Those protections, coupled with the demands of litigation, prevent many disabled policyholders from pursuing their rights. It is also universally the case that insurance disputes arise when the insured is in need of financial assistance and unable to fight. This, in turn, leads to abuse.

Allowing and supporting individual policyholder suits under federal RICO would rectify this situation. Through *Firestone*, *Humana* and *Glenn* and their encouragement of a more full and fair review, this Court has recognized protections afforded to individual policyholders under ERISA. Moorman now asks this Court to allow policyholders to effectively pursue federal RICO claims against conflicted plan administrators using the same evidence deemed relevant in *Glenn*. This would restore needed balance between the intended protections of ERISA and employees' rights to benefits. ERISA would continue to protect fair plan administrators making well-reasoned

decisions. RICO would hold known bad actors accountable by preventing them from hiding behind fraudulent claims handling processes and profiting from the wrongful denial of claims, while still demanding specificity and proof so as to discourage and defeat unsupported claims. RICO's threat of treble damages would help to level the playing field between policyholder and plan administrator. For the first time in thirty-five years, there would be a potential risk associated with wrongfully denying a claim. The result would be more thoughtful and fair claims decisions.

CONCLUSION

The decisions of the lower Courts in this case are improper and contrary to this Court's clear directives, and must therefore be reversed. Moreover, the egregious facts of this case, coupled with Unum's long-standing, well-publicized and proven history of claims mismanagement and wrongful claims denials, make this case appropriate for consideration under federal RICO. Granting certiorari in this case would provide this Court with the opportunity to step beyond *Firestone*, *Humana* and *Glenn* and further enable individual policyholders, through federal RICO, to aid in the fight against insurance fraud and corruption.

So that this Court may consider these issues of national importance more fully, Moorman respectfully requests that this Court grant his Petition for

Certiorari to the United States Court of Appeals for the Eleventh Circuit.

This 14th day of May, 2009.

Respectfully submitted,

RHONDA MICHELE MOORMAN, M.D., J.D.
MEDLAW, INC.

Attorney for Petitioner
Ross Glenn Moorman, Jr.

ROSS GLENN MOORMAN, JR., Plaintiff-Appellant, versus UNUMPROVIDENT CORPORATION, a Delaware corporation, in its individual capacity and as controlling parent of its wholly owned subsidiary, Unum Life Insurance Company of America, a Maine corporation, UNUM LIFE INSURANCE COMPANY OF AMERICA, a Maine corporation, in its individual capacity and as a wholly owned and controlled subsidiary of UnumProvident Corporation, UNUM CORPORATION, a Maine corporation merged to form UnumProvident Corporation, in its individual capacity and as controlling parent company of its wholly owned subsidiary, Unum Life Insurance Company of America, A Maine corporation, Defendants-Appellees.

No. 08-11532

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

303 Fed. Appx. 760; 2008 U.S. App. LEXIS 25402

December 17, 2008, Decided
December 17, 2008, Filed

COUNSEL: For Ross Glenn Moorman, Jr., Appellant: Rhonda Michele Moorman, Moorman Medical Legal Consulting, Inc., DOUGLAS, GA.

For Unumprovident Corporation, Appellee: Nikole Marie Crow, Smith Moore Leatherwood LLP, ATLANTA, GA.

For Unum Life Insurance Co. of America, Appellee: Elizabeth J. Bondurant, Smith Moore Leatherwood LLP, ATLANTA, GA.

For Unum Corporation, Appellee: Kenton Jones Coppage, Smith Moore Leatherwood LLP, ATLANTA, GA.

JUDGES: Before BIRCH and PRYOR, Circuit Judges, and STROM,* District Judge.

OPINION

PER CURIAM:

This appeal presents issues about an insurer's decision to terminate a policyholder's long-term disability benefits. Unum Life Insurance Company of America terminated the long-term disability benefits of Ross Glenn Moorman Jr. after twelve months because there was no medical evidence that Moorman continued to qualify for benefits. Moorman sued Unum under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*, and the Racketeer Influenced Corrupt Organization Act of 1970, 18 U.S.C. §§ 1961 *et seq.* The district court granted summary judgment in favor of Unum and this appeal followed. After oral argument and a thorough review of the record and the parties' briefs, we conclude that the district court did not abuse its discretion or commit any reversible error.

The summary judgment in favor of Unum is **AFFIRMED**.

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* Honorable Lyle E. Strom, United States District Judge for the District of Nebraska, sitting by designation.

App. 3

United States Court of Appeals
For the Eleventh Circuit

No. 08-11532

District Court Docket No.
04-02075-CV-BBM-1

ROSS GLENN MOORMAN, JR.,

Plaintiff-Appellant,

versus

UNUMPROVIDENT CORPORATION,
a Delaware corporation, in its individual capacity and as controlling parent of its wholly owned subsidiary, Unum Life Insurance Company of America, a Maine corporation, UNUM LIFE INSURANCE COMPANY OF AMERICA, a Maine corporation, in its individual capacity and as a wholly owned and controlled subsidiary of UmumProvident Corporation,
UNUM CORPORATION,
a Maine corporation merged to form UnumProvident Corporation, in its individual capacity and as controlling parent company of its wholly owned subsidiary, Unum Life Insurance Company of America,
A Maine corporation,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Georgia

JUDGMENT

(Filed Dec. 17, 2008)

It is hereby ordered, adjudged, and decreed that the attached opinion included herein by reference, is entered as the judgment of this Court.

Entered: December 17, 2008
For the Court: Thomas K. Kahn, Clerk
By: Gilman, Nancy

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

ROSS GLENN MOORMAN, JR., Plaintiff, v. UNUMPROVIDENT CORPORATION, et al., Defendants.	CIVIL ACTION FILE NO. 1:04-CV-2075-BBM

ORDER

(Filed Mar. 4, 2008)

This matter is before the court on Defendant UnumProvident Corporation, et al.'s ("Unum") Motion for Summary Judgment [Doc. No. 110].

I. Factual and Procedural Background

Plaintiff Ross Glenn Moorman, Jr. ("Mr. Moorman") was diagnosed with adenocarcinoma of the rectum on February 15, 1999. His treatment included preoperative chemotherapy and radiation therapy, rectal excision surgery, the creation of a permanent colostomy, and eight months of postoperative chemotherapy.

Beginning in 1997, Unum provided short and long term disability benefits to employees of Southeastern Steam, Inc., where Mr. Moorman was employed. The plan provided for up to 13 weeks of short

term disability benefits and unlimited long term disability benefits so long as the employee remained disabled. For the first 12 months of long term disability, a plan beneficiary is disabled if he is "limited from performing the material and substantial duties of [his] regular occupation due to [the] sickness or injury" and has "a 20% or more loss in [his] indexed monthly earnings due to the same sickness or injury." (Your Short and Long Term Disability Employee Benefits, Southeastern Steam, Inc., Policy No. 516435-012 ("Policy") 34.)

After 12 months, a beneficiary must meet a different definition of disabled to continue to receive payments. That definition is as follows:

> You will continue to receive payments beyond 12 months if:
>
> - you are unable to safely and completely perform 2 activities of daily living without another person's assistance or verbal cueing; or
> - you are cognitively impaired; and
> - you are working in any occupation, and you continue to have a 20% or more loss in your indexed monthly earnings due to your loss of activities of daily living or cognitive impairment; or
> - you are not working, and due to your loss of activities of daily living or cognitive impairment, you are unable to perform the duties of any gainful occupation

> for which you are reasonably fitted by education, training or experience.

(*Id.*) In sum, "[t]o be considered disabled under the plan after 12 months of payments, [the employee] must lose 2 or more activities of daily living or become cognitively impaired while . . . covered under the plan." (*Id.*)

The plan defined activities of daily living ("ADLs"):

> 1. Bathing – washing yourself either in the tub or shower or by sponge bath, with or without equipment or adaptive devices.
>
> 2. Dressing – putting on and taking off all garments, and medically necessary braces or artificial limbs usually worn, and fastening or unfastening them.
>
> 3. Toileting – getting to and from and on and off the toilet, maintaining a reasonable level of personal hygiene, and caring for clothing.
>
> 4. Transferring – moving in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
>
> 5. Continence – voluntarily controlling bowel and bladder function; or in the event of incontinence, maintaining a reasonable level of personal hygiene.

> 6. Eating – getting nourishment into your body by any means once it has been prepared and made available to you.

(*Id.* at 36-37.) Cognitive impairment

> means that you have suffered a deterioration or loss in your intellectual capacity which requires another person's assistance or verbal cueing to protect yourself or others as measured by clinical evidence and standardized tests which reliably measure your impairment in the following areas:
>
> – short or long term memory;
>
> – orientation as to person (such as who you are), place (such as your location), and time (such as day, date and year);
>
> – deductive or abstract reasoning.

(*Id.* at 37.)

Mr. Moorman submitted a claim for disability benefits to Unum on March 7, 1999. Unum approved the claim for short term disability benefits for the maximum 13 weeks under the short term policy. Subsequently, by letter dated June 9, 1999, Unum approved Mr. Moorman's application for long term disability benefits in the amount of $3000 per month. The letter noted that Mr. Moorman would continue to receive benefits so long as he remained disabled, and that Unum may request additional medical information from him to support ongoing benefits. Mr.

Moorman signed a full release allowing Unum to obtain his medical records.

Unum received a set of medical documents from Gary Newcomer, M.D. ("Dr. Newcomer"), Mr. Moorman's primary care physician, on October 1, 1999. (Administrative R. 99-103.) Among other things, the documents noted that Mr. Moorman was to undergo chemotherapy for another six to eight months. He was prohibited from lifting more than five pounds or from prolonged walking or standing. Dr. Newcomer checked a box on one of the records indicating that Mr. Moorman was disabled.[1] He also checked another box indicating that Mr. Moorman could care for himself. Dr. Newcomer stated that it was unknown when Mr. Moorman would experience a significant change in functional ability.

Mr. Moorman returned to work on a part time basis on August 5, 1999. Under the Work Incentive Benefit Provision ("WIBP") of the Unum plan, Mr. Moorman was entitled to continued benefits in addition to the salary he earned once he began working again. Mr. Moorman's part time schedule consisted of working four hours per day, four days a week. On January 7, 2000, Unum informed Mr. Moorman that he was not in fact entitled to benefits under the WIBP. Accordingly, Unum reduced Mr. Moorman's monthly benefits and requested that he reimburse Unum for an overpayment in the amount of $4873.76.

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[1] "Disabled" was not defined on the form.

Mr. Moorman believed that he was eligible for the WIBP, so he refused to return what Unum termed the overpayment. In response, Unum reduced his monthly benefit payments to zero, and did not pay him any benefits from January 15, 2000, to May 15, 2000.

On January 12, 2000, Unum sent Mr. Moorman a letter informing him that it was in the process of reviewing his file to see if he would continue to meet the definition of disabled after receiving 12 months of benefits. On May 11, 2000, Unum terminated Mr. Moorman's benefits permanently. In a letter explaining the decision, Unum stated that there was no medical evidence in Mr. Moorman's file to support a finding that he had lost at least two ADLs. Unum told Mr. Moorman that he could appeal the decision in writing, and should include any documentation that he wished Unum to consider.

Five days later, Unum sent Mr. Moorman another letter reversing its earlier decision that Mr. Moorman was not entitled to WIBP benefits. Unum told Mr. Moorman that he was entitled to those benefits and that it would refund the amount it had withheld from January 15, 2000, to April 9, 2000. The Unum representative who sent these letters was Customer Care Specialist Adam Boothby ("Mr. Boothby"). Mr. Boothby is not a doctor and has no medical training.

Mr. Moorman appealed the termination of his benefits on August 2, 2000. At this time, he was represented by an attorney named Curtis Farrar ("Mr.

Farrar"). Mr. Farrar wrote to Unum that Mr. Moorman's permanent colostomy "affects the daily living of toileting and continence." (Letter from Curtis Farrar to Adam Boothby, UnumProvident Corp., Aug. 2, 2000.) Mr. Farrar also stated that Mr. Moorman lacked the "mental stamina" to perform his job regularly. (*Id.*) Mr. Farrar requested a copy of all pertinent documents contained in his Unum file. Unum complied on August 9, 2000.[2]

On August 15, 2000, Unum notified Mr. Moorman that his appeal had been received. It informed Mr. Moorman that his entire claim file and previously submitted medical records were under review, and that Unum would contact Mr. Moorman if more information was needed. Unum subsequently sent Mr. Moorman at least five letters extending the time for its decision on the appeal, dated September 29, 2000, November 29, 2000, December 29, 2000, February 6,

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[2] Mr. Moorman asserts that Mr. Farrar never received the file. Mr. Boothby later identified the documents he claimed to have sent to Mr. Farrar. (*See* Dep. of Adam Douglas Boothby, Nov. 30, 2007, at Ex. 25.) The administrative record also reflects that the documents were sent. (Administrative R. 159-60.) Mr. Moorman correctly points out that no one appears to have sent Mr. Farrar a copy of the Clinical Review Request upon which the denial of his appeal was based, a copy of Dr. Newcomer's March 19, 2001, letter, or other updated information from Mr. Moorman's file. However, the record does not reflect any further requests for documents from Mr. Farrar. When Mr. Moorman's current counsel assumed representation of Mr. Moorman in 2003, she requested his file and there is no indication that she did not receive it.

2001, and March 7, 2001. None of these letters contained requests for additional information or medical records from Mr. Moorman.

Lead Appeals Specialist Kari L. Luedtke ("Ms. Luedtke") sent three faxed requests to Dr. Newcomer, dated October 11, 2000, November 17, 2000, and December 21, 2000. She asked for any new or updated office notes or test results, and inquired into Mr. Moorman's current restrictions and limitations. Receiving no response, Ms. Luedtke wrote to Mr. Farrar on January 23, 2000, seeking his assistance in obtaining the requested information. At Mr. Farrar's request, Ms. Luedtke forwarded the fax for Dr. Newcomer to Mr. Farrar on January 29, 2001.

Ms. Luedtke is not a doctor and has no medical training. On March 7, 2001, she submitted a Clinical Review Request[3] for Mr. Moorman, posing two questions: whether the medical evidence supported Mr. Moorman's inability to perform two ADLs from May 15, 2000, through the present; and whether the medical evidence showed that Mr. Moorman was cognitively impaired from May 15, 2000, through the

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[3] The administrative record contains two copies of the Clinical Review Request, one with only Jan Oliver's notes on it, and the second with the notes from Dr. Nancy Beecher's review a few days later. Ms. Oliver's notes on both copies are the same. When the court refers to the Clinical Review Request, it means the complete version with both Ms. Oliver's and Dr. Beecher's notes on it. The date, March 7, 2001, is the date Ms. Luedtke submitted the request.

present. Jan Oliver ("Ms. Oliver"), a nurse in Unum's Chattanooga, Tennessee, offices, reviewed Mr. Moorman's record first. She wrote that she "needed [an] update" on Mr. Moorman's current condition and treatment, and noted that any new records would be reviewed and forwarded to the file upon receipt. (Clinical Review Request, Mar. 7, 2001, at 2.) According to Ms. Oliver, "[d]etermining [Mr. Moorman's restrictions and limitations] will not be possible without knowing his treatment regime." (*Id.*) It appears to the court that no new medical records were ever obtained for review by Ms. Oliver. On the basis of the information in the file, Ms. Oliver's conclusion was that the medical evidence would support "impairment" from February 15, 1999, to June of 2000, to allow six to eight months to complete post-surgery chemotherapy and three months to recover from the side effects. (*Id.* at 3.) Ms. Oliver noted that Mr. Moorman's recovery might be longer, depending on the type of drug given. She did not find evidence to support cognitive impairment.[4]

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[4] Ms. Oliver outlined several of the usual side effects of chemotherapy, including severe weakness and fatigue, nausea, vomiting, and profuse diarrhea. She observed that chemotherapy can cause cognitive difficulties such as forgetfulness and lightheadedness, and that depression and anxiety sometimes accompany body-altering procedures such as the one Mr. Moorman underwent. (*See* Clinical Review Request, Mar. 7, 2001, at 2.) However, it is important to note that Ms. Oliver did not find evidence that Mr. Moorman suffered any of these debilitating symptoms from his medical records.

Nancy B. Beecher, M.D. ("Dr. Beecher") reviewed Ms. Oliver's findings. She agreed that the medical records did not support cognitive impairment. She also found that there was no evidence in support of Mr. Moorman's inability to perform two ADLs, but noted that there were no medical records dated after May of 2000. Dr. Beecher wrote, in part:

> I do not see any medical records in the file dated after 5/00. His lawyer says he can't work due to the colostomy and it's [sic] care and due to cognitive impairment. It doesn't make sense that he could work part time but not full time if he has a cognitive impairment. Usually in the hospital they would have an osteotomy[5] team instruct him in care of his colostomy and he should be adept at placing the bags and removing them by the time he leaves the hospital, so there should be no ADL issues with this, or with showering and bathing, so I do not understand what ADL issues there might be.

(*Id.*) Dr. Beecher completed her review on March 27, 2001.

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[5] Dr. Beecher testified in her deposition that she actually meant to write "otomy" or "ostomy" as a generic term to refer to doctors who assist patients with some diversion of their bowel or urinary system, such as a colostomy. (Dep. of Nancy Beecher, M.D., Dec. 12, 2007 ("Beecher Dep.") 156:10-23.) An "osteotomy" is an orthopedic procedure involving cutting a portion of bone. It is undisputed that Mr. Moorman did not have the latter procedure performed.

On March 19, 2001, Unum received a letter from Dr. Newcomer updating Mr. Moorman's condition and detailing his permanent restrictions. According to him, Mr. Moorman experienced chronic irritation of the stoma, meaning that he suffered persistent pain and bleeding, in addition to leaking of colonic contents almost every day. As a result of the rectal excision, Mr. Moorman experienced difficulty in sitting for longer than 15 minutes at a time and needed frequent position changes. The chemotherapy caused frequent episodes of weakness. Dr. Newcomer stated that Mr. Moorman was unable to work a full day. Mr. Moorman's specific restrictions were:

1. He may work 16 hours per week (i.e. 4 days per week at 4 hours per day).

2. He should be sitting for 30 minutes or less each hour, with opportunity for frequent positional changes.

3. No lifting over 15 pounds, with no excessive bending, twisting, pushing, or pulling. He must avoid straining at all times since intra-abdominal pressure can be transmitted to the colostomy bag itself, resulting in bag rupture or herniation of the distal colon.

4. He should have access to a bathroom at all times in case of bag leakage.

(Letter from Gary Newcomer, M.D., to Karl [sic] L. Luedtke, UnumProvident Corp., Mar. 19, 2001.) Dr.

Beecher did not see this letter before she completed her review of Mr. Moorman's file.

In the same letter, Dr. Newcomer informed Unum that he had not treated Mr. Moorman since February of 2000, at which time Mr. Moorman's "care was assumed by his son, Ross Moorman, III, M.D." (*Id.*) Dr. Newcomer suggested that Unum "may need to contact Dr. Moorman for Mr. Moorman's clinical course since February of 2000." (*Id.*) Unum does not recognize a family member, such as a spouse, child, parent, or sibling, as a doctor for purposes of submitting a claim. (Policy 31, 56, 68.) Unum did not contact Dr. Moorman about Mr. Moorman's claim.

On March 29, 2001, Unum informed Mr. Moorman in writing that his appeal had been rejected and the decision terminating his benefits upheld. In the letter, Ms. Luedtke specifically noted that, though Unum received Dr. Newcomer's March 19, 2001, letter, it did not receive the requested medical records for the period after May 15, 2000. The letter explained that Mr. Moorman's appeal was being denied because his file lacked any medical evidence that he was cognitively impaired or had lost at least two ADLs. Ms. Luedtke concluded by inviting Mr. Moorman to submit any new medical evidence from the period May 15, 2000, through the present in support of Mr. Moorman's inability to safely and completely perform two ADLs, or any cognitive impairment. Unum requested that any such documents be submitted by April 26, 2001. Unum later extended the deadline to May 31, 2001.

On March 10, 2003, Rhonda M. Moorman, M.D., J.D. ("Ms. Moorman") contacted Unum to inform it that she was now the attorney handling Mr. Moorman's case.[6] She requested his file, which Unum sent to her on March 11, 2003. In a letter dated March 17, 2003, Ms. Moorman objected to Unum's denial of Mr. Moorman's appeal, which she characterized as based on a lack of medical documentation due to Dr. Newcomer's slow response to requests for information. Ms. Moorman stated that Mr. Moorman's treatment at the time had been provided by Thomas Neal, M.D. ("Dr. Neal"), William M. Mendenhall, M.D. ("Dr. Mendenhall"), Robert R. Carroll, M.D. ("Dr. Carroll"), and Anthony P. McDonald, M.D. ("Dr. McDonald"). Ms. Moorman asked Unum to reconsider Mr. Moorman's appeal.

Ms. Luedtke responded by letter dated April 22, 2003. She explained that, because Dr. Newcomer had said that Mr. Moorman's care had been undertaken by his son, Dr. Moorman, who was located in Georgia, Unum had not requested records from the other physicians, who were located in Florida. Ms. Luedtke also noted that Unum had still not received any medical evidence that demonstrated that Mr. Moorman had lost two or more ADLs or was cognitively impaired. Unum thus considered the administrative record for Mr. Moorman's claim to be closed.

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[6] Ms. Moorman is the attorney of record in the case before this court as well.

Mr. Moorman filed suit on July 16, 2004. His 15 count Complaint alleged violation of a variety of state laws; wrongful denial of benefits under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132; violation of fiduciary duty under ERISA; failure to provide documents under ERISA; and violation of the federal Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1961 et seq. On February 17, 2005, this court ruled that ERISA governed the plan and preempted Mr. Moorman's state law claims. Mr. Moorman sought and received an interlocutory appeal of that ruling, and it was affirmed by the Eleventh Circuit on September 18, 2006. The case proceeded to discovery on Mr. Moorman's remaining claims. Unum has now moved for summary judgment on all claims.

II. Analysis

A. Wrongful Denial of ERISA Benefits

The Supreme Court established three distinct standards for reviewing an administrator's decision to deny benefits under a plan governed by ERISA. *See Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989). If the plan does not grant the administrator discretion in deciding claims, a court will review the decision to deny a claim de novo. If the plan does grant such discretion, a court reviews the decision under an arbitrary and capricious standard. Where the plan grants discretion to the administrator and the administrator has a conflict of interest, a court is

to apply a heightened arbitrary and capricious review. *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1134 (11th Cir. 2004). "[I]n most cases where a company both administers and funds a plan, a conflict of interest arises, thus triggering heightened arbitrary and capricious review." *Id.* at 1135.

"When making a benefit determination under the policy, UNUM has discretionary authority" to interpret the provisions of the policy and determine eligibility. (Policy 1.) *See Kirwan v. Marriott Corp.*, 10 F.3d 784, 788 (11th Cir. 1994) ("This circuit has interpreted *Bruch* to mandate *de novo* review unless the plan *expressly* provides the administrator discretionary authority to make eligibility determinations or to construe the plan's terms."). Unum also both administers and funds the plan. Unum retains "the ability to control the ultimate disposition of the claim," and thus has a conflict of interest. *Williams,* 373 F.3d at 1135. The court will review Mr. Moorman's claim under the heightened arbitrary and capricious standard.

The Eleventh Circuit uses what is essentially a three-step approach to analyzing an ERISA claim involving a conflicted administrator. *See Williams,* 373 F.3 at 1137-38; *Wise v. Hartford Life & Accident Ins. Co.,* 360 F. Supp. 2d 1310, 1317-18 (N.D. Ga. 2005) (Story, J.). The analysis begins by asking whether the decision made by the administrator was incorrect under de novo review. If the decision was wrong, the court then determines whether it was nevertheless reasonable. Finally, the court applies

heightened arbitrary and capricious review to a wrong but reasonable decision.

1. Was Unum's decision de novo wrong?

A "wrong" determination describes "the conclusion a court reaches when, after reviewing the plan documents and disputed terms, *de novo,* the court disagrees with the claims administrator's plan interpretation." *HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.,* 240 F.3d 982, 993 n.23 (11th Cir. 2001). "[R]eview is confined to the evidence that was before the administrator when the claim for benefits was denied." *Richards v. Hartford Life & Accident Ins. Co.,* 153 Fed. Appx. 694, 696 n.1 (11th Cir. 2005) (*citing Lee v. Blue Cross/Blue Shield of Ala.,* 10 F.3d 1547, 1550 (11th Cir. 1994)). In terminating Mr. Moorman's benefits, Unum found that he was not cognitively impaired and had not lost two or more ADLs. Mr. Moorman was required to meet either of those criteria in order to continue receiving benefits after 12 months. The court will review the evidence de novo to see if it agrees or disagrees with Unum.

i. Cognitive Impairment

There is no medical evidence that Mr. Moorman either was or is cognitively impaired. Cognitive impairment is defined as "deterioration or loss in your intellectual capacity which requires another person's assistance or verbal cueing to protect yourself or others as measured by clinical evidence and standardized

tests which reliably measure your impairment" in the areas of short or long term memory, orientation as to person, place, and time, or deductive or abstract reasoning. (Policy 37.) The only reference in the administrative record pertaining to Mr. Moorman's alleged cognitive impairment is Mr. Farrar's mention of Mr. Moorman's problems with "mental stamina." (Letter from Curtis Farrar to Adam Boothby, UnumProvident Corp., Aug. 2, 2000.) In the Clinical Review Request, Ms. Oliver described some typical side effects of chemotherapy, such as forgetfulness and lightheadedness, but did not make a finding that Mr. Moorman suffered such side effects.

Mr. Moorman took several medications for pain and to help him sleep. Ms. Oliver noted on the Clinical Review Request that his medications were Lotensin,[7] Atarax,[8] Lortab,[9] and Ambien.[10] The side effects of medication that a claimant takes should not be ignored in evaluating the claimant's disability. *Godfrey v. BellSouth Telecomms., Inc.*, 89 F.3d 755, 758-59 (11th Cir. 1996). However, the record is bare as to any side effects Mr. Moorman may have suffered.

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[7] The court understands Lotenzin [sic] to be a medication taken to control high blood pressure.

[8] Atarax is used to relieve nasal and non-nasal allergy symptoms.

[9] Lortab is a narcotic pain reliever.

[10] Ambien is a sedative.

Mr. Moorman provides two citations to the administrative record in support of his claim for cognitive impairment, (*see* Pl.'s Resp. to Defs.' Mot. for Summ. J. 16 n.5), but the court's investigation reveals that both refer to copies of the same letter submitted to Unum by Mr. Farrar. The relevant portions of the letter read: "[Mr. Moorman's] physical ability to work is simply decreased to 16 to 20 hours per week. Before this illness, he was able to work 60 to 70 hours per week. Also, he does not have the mental stamina to perform his daily job on a regular basis." (Letter from Curtis Farrar to Adam Boothby, UnumProvident Corp., Aug. 2, 2000.) First, the court does not construe a vague reference by Mr. Moorman's then-lawyer to lack of "mental stamina" to be a claim of cognitive impairment. Mr. Moorman never uses the words "cognitively impaired" to describe his condition, nor does he utilize any of the terms in the plan's definition of cognitive impairment, such as "deterioration" or "loss" of "intellectual capacity." Second, the court does not know what side effects are typically caused by the medications Mr. Moorman took[11] and what, specifically, he claims to have experienced. Finally, the medical evidence in the administrative record shows only that Mr. Moorman was taking those medications as of September 28, 1999. There is

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[11] The court conducted an internet search to determine broadly what the medications, described briefly above, are used to treat, but cannot properly rely on its own such research to determine what side effects may be caused by these drugs, much less what side effects Mr. Moorman may have experienced.

nothing to indicate whether he continued to take them after May 11, 2000, and, if so, whether he continued to experience side effects.[12] Failing to find any evidence of cognitive impairment due to side effects from necessary medication is not the same as "ignoring" side effects suffered by a claimant.

"A plaintiff suing under this provision bears the burden of proving his entitlement to contractual benefits." *Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1040 (11th Cir.1998). Mr. Moorman did not present any evidence that he suffered cognitive impairment, much less the clinical evidence and standardized tests required by the plan. The court's de novo conclusion is that Unum was correct in denying Mr. Moorman's claim of disability due to cognitive impairment.

ii. Loss of at Least Two ADLs

Mr. Moorman asserts that he has lost the two ADLs of toileting and continence. (Pl.'s Resp. to Defs.' Mot. for Summ. J. 14; Letter from Curtis Farrar to Adam Boothby, UnumProvident Corp., Aug. 2, 2000.)

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[12] The date May 11, 2000, is relevant because it marks the point at which Mr. Moorman had received 12 months of long term disability payments. In order to continue receiving benefits beyond 12 months, Mr. Moorman was required to demonstrate cognitive impairment (or a loss of at least two ADLs). It is undisputed that Mr. Moorman qualified for long term disability benefits during the first 12 months he received payments, because that definition of disability is different.

The court has not found any mention that Mr. Moorman has difficulty with the other four ADLs of bathing, dressing, transferring, or eating, so it will consider only toileting and continence.

Mr. Moorman has a permanent colostomy as a result of his cancer treatment. The court understands a colostomy to be an opening in the body through which the remaining bowel is diverted to allow feces to leave the body. A colostomy bag is sealed around the opening to catch the waste. It is this condition that forms the basis of Mr. Moorman's assertion that he has lost the ADLs of toileting and continence. Toileting is defined as "getting to and from and on and off the toilet, maintaining a reasonable level of personal hygiene, and caring for clothing." (Policy 36.) Though Mr. Moorman's use of a toilet is now obviously different, the court cannot find any indication in the record that he is unable to toilet in the altered fashion associated with a colostomy. The ADL of toileting relates to the physical ability to relieve oneself of urine and bowel movements. Mr. Moorman now uses a colostomy bag to relieve himself of feces. Because he no longer requires the traditional mechanism, the actual toilet, to do so, does not mean that he is unable to toilet.

Nothing in the record suggests that Mr. Moorman was unable to maintain a reasonable level of personal hygiene or care for his clothing. According to a letter

from Dr. Newcomer dated March 19, 2001,[13] Mr. Moorman periodically experienced bag leakage. The court would expect that the natural consequence of bag leakage might be some soiling of Mr. Moorman's clothes, but there is no evidence that this occurred or to what extent. There is no evidence that Mr. Moorman was unable to clean himself or his clothes after a leak, or was otherwise unable to maintain a *reasonable* level of personal hygiene.[14] Moreover, the

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[13] As noted above, Dr. Beecher did not see this letter before she concluded that Mr. Moorman had not lost any ADLs. Mr. Moorman points out that Dr. Beecher testified in deposition that she should have been provided with the letter when reviewing the Clinical Review Request because it raised several "issues that would need to be resolved one way or another." (Beecher Dep. 107:24-25.) The court must confine its review to the administrative record. *Lee*, 10 F.3d at 1550 ("Application of the arbitrary and capricious standard requires us to look only to the facts known to the administrator at the time the decision was made to deny . . . coverage."). However, if the court could consider the deposition testimony of Dr. Beecher, it would observe that she later stated that her opinion on the two questions posed in the Clinical Review Request would be the same even after reviewing the letter. (Beecher Dep. 233:9-15.)

[14] The lone references to toileting and continence in Mr. Moorman's Response Brief to the Motion for Summary Judgment are found on page 14:

> Plaintiff never claimed to have a problem with showering or bathing. To the contrary, Mr. Farrar, in Plaintiff's appeal, specifically informed Defendants that Plaintiff's ADL issues were with toileting and continence, which are listed as two separate ADLs in the policy. (AR 134, 158). Under both toileting and continence, Plaintiff satisfies the definition of disability if he is 'unable to maintain a reasonable level of

(Continued on following page)

letter from Dr. Newcomer, though dated March 19, 2001, indicated that Dr. Newcomer had not treated Mr. Moorman since February of 2000. There is thus no evidence after February of 2000 that Mr. Moorman continued to experience leakage of his colostomy bag.

> personal hygiene.'(AR 250). In addition to cognitive impairment from the narcotic pain and other medications that he was taking, this in fact formed the basis for Plaintiff's continuing disability – as was fully set forth both in Plaintiff's appeal and Dr. Newcomer's March 19, 2001 letter. (AR 134, 158, 188). Nonetheless, Dr. Beecher never considered or addressed the ADLs of toileting and continence – most likely because she knew nothing 'about caring for the colostomy on a day-to-day basis.' (Beecher Dep. at 161:1-162:20) – the very heart of the toileting and continence issues for a colostomate. (*See generally,* SF ¶¶ 194-201).

(Pl.'s Resp. to Defs.' Mot. for Summ. J. 14.) To emphasize, Mr. Moorman states only that he "satisfies the definition of disability *if* he is 'unable to maintain a reasonable level of personal hygiene.'" (*Id.* (emphasis added).) Not only does Mr. Moorman not allege that he was unable to do so, but he provides no evidence for the court to review on this point.

It is furthermore incorrect to state that Dr. Beecher did not consider or address the ADLs of toileting or continence. In fact, Dr. Beecher wrote in the Clinical Review Request that "[u]sually in the hospital they would have an osteotomy [sic] team instruct him in care of his colostomy and he should be adept at placing the bags and removing them by the time he leaves the hospital, *so there should be no ADL issues with this.*" (Clinical Review Request, March 7, 2001, at 3 (emphasis added).) Because there was no evidence in the record that Mr. Moorman had any problems maintaining a reasonable level of personal hygiene, Dr. Beecher concluded that he had not lost the ADLs of toileting and continence.

Mr. Moorman's burden is to show that he is entitled to disability benefits on an ongoing basis. In any event, the standard is not a perfect level of personal hygiene. The court has been provided with no evidence that having a colostomy bag, even one that may leak from time to time, prevents a person from maintaining reasonable personal hygiene. Thus, Mr. Moorman has not lost the ADL of toileting.

Continence is defined as "voluntarily controlling bowel and bladder function; or in the event of incontinence, maintaining a reasonable level of personal hygiene." (Policy 36.) Again, Mr. Moorman no longer controls his bowel function in the traditional way. It does not follow, however, that he is *unable* to control his bowel function by properly caring for his colostomy bag. The court sees no evidence that Mr. Moorman is incontinent. Assuming, contrary to the evidence, that he is incontinent, there is no evidence that he cannot maintain a reasonable level of personal hygiene. Mr. Moorman has not lost the ADL of continence.

The March 19, 2001, letter from Dr. Newcomer does not change this conclusion. Dr. Newcomer stated that Mr. Moorman had a great deal of difficulty with his colostomy, including chronic irritation of the opening, which resulted in pain and bleeding. Mr. Moorman also experienced difficulty with his rectal excision. According to Dr. Newcomer, Mr. Moorman was permanently restricted to a work week of 16 hours; should be seated for less than 30 minutes each hour; could not lift over 15 pounds or strain at all;

and required access to a bathroom at all times. These symptoms and permanent restrictions speak to the suffering that Mr. Moorman underwent due to his disease. However, even assuming that these conditions persisted after February of 2000, they do not establish that Mr. Moorman lost the ADLs of toileting or continence.

"A plaintiff suing under [ERISA] bears the burden of proving his entitlement to contractual benefits." *Horton,* 141 F.3d at 1040. The evidence that Mr. Moorman has come forth with is the fact that he has a colostomy and that, as of February 2000, the bag leaked sometimes. That is insufficient to persuade this court that Unum was wrong in concluding that Mr. Moorman had not lost the ADLs of either toileting or continence.

iii. Conclusion

In sum, de novo review of Unum's decision to deny Mr. Moorman's benefits leads the court to conclude that Unum was correct in its denial.[15] Mr.

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[15] The court notes here that the bulk of Mr. Moorman's Response Brief opposing the Motion for Summary Judgment is comprised of arguments that pertain only to the reasonableness of Unum's denial of benefits. This is true even of the section that Mr. Moorman entitled, *Wise* Test, Step 1: *De Novo* Review. As illustration, the subsections of that section are:

> At the time Defendants denied Plaintiff's claim, Defendants had neither sought nor obtained current medical information from any source;

(Continued on following page)

Moorman was diagnosed with rectal cancer in February of 1999. Unum paid him short term disability

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> The decision to deny Plaintiff's claim for benefits was made not based upon any reliable medical information, but as a sanction for Plaintiff's having returned to work part-time;
>
> Defendants terminated Plaintiff's benefits without obtaining any medical information, and the decision was made by a claims representative who was not competent to do so;
>
> Knowing that Plaintiff's medical file was incomplete, Defendants nonetheless refused to obtain Plaintiff's updated medical records from his identified treating physicians or request that Plaintiff provide those;
>
> Defendants' in-house paper review was not a reasonable examination of Plaintiff's medical condition/disability;
>
> Though clearly not competent to make a determination regarding Plaintiff's disability, Defendants' agents refused to obtain Plaintiff's updated medical records, request additional medical assistance, or request that Plaintiff undergo an [independent medical examination];
>
> In denying Plaintiff's appeal, Defendants ignored credible evidence submitted by Plaintiff's treating physician.

('Pl.'s Resp. to Defs.' Mot. for Summ. J. 4, 7, 9, 10, 12, 14, 15.) These subsections, and their contents, fail to recognize the fact that Mr. Moorman, as the plaintiff, bears the burden of showing that he is entitled to these benefits. They also provide little in the way of argument that Unum's decision to deny benefits was wrong. The court emphasizes this point in support of its finding that the medical records it must rely on in conducting the de novo review are exceptionally sparse, and none were provided from the period of time after the disability benefits were terminated.

benefits and 12 months of long term disability benefits. After 12 months, Unum concluded that there was no evidence that Mr. Moorman had lost at least two ADLs, specifically, toileting and continence, or was cognitively impaired. Mr. Moorman therefore no longer met the definition of disabled, and so Unum denied him further payments. Based on its own review of the administrative record and the medical evidence, the court agrees with Unum. After May 15, 2000, Mr. Moorman no longer met the definition of disabled under his plan, and was not entitled to further benefits.

2. Was Unum's decision reasonable?

Though a finding that Unum's denial of benefits was de novo correct would ordinarily end the inquiry, the court will also explain why it finds the decision to have been entirely reasonable. Unum's policy uses two different definitions of long term disability, one for the first 12 months, and one for payments after 12 months. Mr. Moorman was clearly "limited from performing the material and substantial duties of [his] regular occupation" due to his cancer, and had a resulting loss of over 20% of his monthly earnings for the first 12 months. (Policy 34.) He was therefore disabled under the definition for that period. However, when Unum reviewed his file, it determined that he did not meet the second definition of disabled in order to continue receiving payments past that 12 month period.

The medical evidence that Unum had in making that decision was a set of documents sent by Dr. Newcomer and received by Unum on October 1, 1999. The restrictions that Dr. Newcomer set out were no lifting over five pounds, no frequent bending, twisting, pushing, pulling, walking, prolonged standing, or commercial driving. Dr. Newcomer listed Mr. Moorman's medications, and his ongoing chemotherapy. None of the documents submitted by Dr. Newcomer indicated that Mr. Moorman was cognitively impaired or had lost at least two ADLs. On this basis, Unum concluded that Mr. Moorman was not entitled to benefits after 12 months. The court finds this decision to be reasonable. Unum gave Mr. Moorman notice that it was evaluating his file for evidence of disability beyond 12 months. Mr. Moorman had returned to work by this time, and indicated on one of the October 1, 1999, documents that he was able to care for himself. (*See* Administrative R. 103.) Though these two facts are not conclusive, there was no additional indication that Mr. Moorman was either cognitively impaired, or unable to bathe, dress, toilet, transfer, remain continent, or eat.

Mr. Moorman appealed the termination of his benefits. In evaluating the appeal, Unum sent Dr. Newcomer three faxed requests for updated medical records. When Dr. Newcomer did not respond, Unum notified Mr. Moorman's then-lawyer and asked for his assistance in securing the information. In the meantime, Mr. Moorman's file was reviewed by a registered nurse, Ms. Oliver, and a medical doctor, Dr. Beecher.

Dr. Newcomer finally responded with a letter, dated March 19, 2001, stating that he had not treated Mr. Moorman since February of 2000, and that Mr. Moorman's son, Dr. Moorman, had assumed his father's care. No medical records were included with Dr. Newcomer's letter. Unum did not request medical records from Dr. Moorman because it does not accept a physician who is a family member for purposes of pursuing a claim.[16] Unum denied Mr. Moorman's appeal.

The court also finds this decision to be reasonable. Unum gave Mr. Moorman notice and time to submit additional records and evidence in his favor. It submitted his file for review by a registered nurse and a doctor. The court understands that Dr. Beecher did not review the Dr. Newcomer's letter. However, as discussed thoroughly elsewhere, the letter did not contain any information from after the time Dr. Newcomer stopped treating Mr. Moorman, February of 2000. At the time of Dr. Beecher's review, this information was over a year old. It would not have supported Mr. Moorman's claim of ongoing disability.

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[16] Mr. Moorman presses the argument that Dr. Moorman merely coordinated Mr. Moorman's care and was not his treating physician. In his letter, Dr. Newcomer states that Mr. Moorman's "care was assumed by his son." (Letter from Gary Newcomer, M.D., to Karl [sic] L. Luedtke, UnumProvident Corp., Mar. 19, 2001.) Regardless of Dr. Moorman's actual role in Mr. Moorman's treatment, it was certainly reasonable for Unum to believe, based on Dr. Newcomer's letter, that Dr. Moorman was in fact treating his father, which would disqualify him under Unum's provisions.

Unum's handling and subsequent denial of Mr. Moorman's appeal was reasonable.

Mr. Moorman faults Unum for failing to contact his other treating physicians, specifically, Drs. Neal, Mendenhall, Carroll, and McDonald. The court notes that the latter three doctors are all located in Florida.[17] (*See* Administrative R. 36.) Given Dr. Newcomer's letter to the effect that Mr. Moorman's care had been transferred to his son in Georgia, it was reasonable for Unum to believe that Mr. Moorman's Florida doctors no longer had a hand in his care. The court does not know where Dr. Neal is located or when he treated Mr. Moorman. However, the medical records submitted most recently to Unum were the documents received by Dr. Newcomer on October 1, 1999. At least one of those records was headed, "to be completed by attending physician." (*Id.* at 102.) Again, the court believes it was reasonable for Unum to request medical records from Dr. Newcomer, thinking him to be Mr. Moorman's primary physician.

In a related argument, Mr. Moorman asserts that, with the exception of Ms. Luedtke's January 23, 2001, letter to Mr. Farrar, requesting assistance in retrieving medical records from Dr. Newcomer, he was never told that his medical file was incomplete. The court disagrees both with that characterization of the facts and with its corresponding implication as to

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[17] Mr. Moorman underwent his surgery and initial treatment at Shands Cancer Center at the University of Florida.

which party bears the burden of persuasion in an ERISA case. Mr. Moorman's benefits were terminated on May 11, 2000, because there was "no evidence, in our file, that supports the level of impairment" under the plan. (Letter from Adam Boothby, UnumProvident Corp., to Mr. Moorman, May 11, 2000.) In the termination letter, Mr. Moorman was informed of his right to appeal and told that he should include any documentation that he wished Unum to consider.[18] The record does not reflect that Mr. Moorman submitted any documentation. Mr. Moorman admits that Unum asked for medical records in its January 23, 2001, letter. The only response was Dr. Newcomer's March 19, 2001, letter, which contained information only about the time period Dr. Newcomer treated Mr. Moorman – February 2000 and before. Mr. Moorman's appeal was then rejected on March 29, 2001, because there was no medical evidence to support his claim of disability. That letter also invited Mr. Moorman to submit new medical evidence.[19] Thus, the record shows at least two other times when Mr. Moorman was informed that his medical record did not support his claims.

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[18] When Mr. Farrar submitted the August 2, 2000, letter of appeal, he requested a copy of the pertinent documents in Mr. Moorman's file. He should have been able to see for himself the ways in which the file was lacking.

[19] The deadline for Mr. Moorman to submit new evidence was April 26, 2001, giving him ample time to respond, and was in fact later extended to May 31, 2001.

Moreover, Mr. Moorman was invited to supplement the record and declined to do so. Mr. Moorman bears the burden of demonstrating that he is entitled to payments beyond the 12 months of benefits he has already received, and to do that, he must show that he cannot perform at least two ADLs or is cognitively impaired. The record is absolutely devoid of medical records or any other evidence that he meets either criterion. Even if Mr. Moorman was entitled to plead ignorance that his file was incomplete, which the court finds he is not, he may not use that as an excuse to avoid carrying the burden of demonstrating eligibility for benefits.

3. Heightened arbitrary and capricious review.

Having concluded both that Unum's decision was de novo correct *and* was reasonable, there is no reason for the court to apply heightened arbitrary and capricious review.

4. Conclusion.

The court's de novo review of Unum's denial of benefits shows it to be correct. There is no evidence to support Mr. Moorman's claim that he is disabled as defined by his plan. Unum's decision was also entirely reasonable. It was based on the undisputed evidence before it, as reviewed by medical professionals. Unum gave Mr. Moorman several chances to submit additional medical evidence that he

continues to be disabled, and he has failed even up to this day to do so. Accordingly, Unum's Motion for Summary Judgment as to Mr. Moorman's claim for wrongful denial of benefits is GRANTED.

B. Breach of Fiduciary Duty under ERISA

Mr. Moorman claims that Unum breached its fiduciary duty under ERISA when it wrongfully denied his claim for benefits; when it failed to give him adequate notice and an opportunity to perfect his claim and appeal; and when it failed to decide his appeal within 120 days. (*See* Compl. ¶ 213; Pl.'s Resp. to Defs.' Mot. for Summ. J. 24, 28.) Mr. Moorman asserts this claim for relief under 29 U.S.C. § 1132(a)(3), which provides for a cause of action to be brought by any plan beneficiary to enforce an ERISA provision. (Compl. ¶ 215.) A plan administrator under ERISA must provide adequate notice when a claim is denied and must set forth the specific reasons for the denial in language that the claimant can understand. The claimant must then be afforded a full and fair review of the denial. 29 U.S.C. § 1133.

"[A]n ERISA plaintiff who has an adequate remedy under Section [1132](a)(1)(B) cannot alternatively plead and proceed under Section [1132](a)(3)." *Ogden v. Blue Bell Creameries U.S.A., Inc.*, 348 F.3d 1284, 1287 (11th Cir. 2003). Section 1132(a)(3) serves as a catch-all provision that provides relief only for injuries that are not otherwise adequately provided for under ERISA. *Varity Corp. v. Howe*, 516 U.S. 489,

512 (1996); *Katz v. Comprehensive Plan of Group Ins.*, 197 F.3d 1084, 1088-89 (11th Cir. 1999). The remedy for Mr. Moorman's injury, the denial of his benefits, is fully provided for in Section 1132(a)(1)(B).

In determining whether a plaintiff is entitled to pursue a claim under the catch-all provision, the court is to consider whether the allegations supporting the claim under Section 1132(a)(3) are also sufficient to state a cause of action under Section 1132(a)(1)(B). *Jones v. Am. Gen. Life & Accident Ins. Co.*, 370 F.3d 1065, 1073-74 (11th Cir. 2004). Mr. Moorman's claim is that Unum's "implementation and use of the bad faith scheme to deny [his] claim and appeal, while acting as fiduciaries pursuant to ERISA, . . . constitutes a violation of ERISA" under Section 1132(a)(3). (Compl. ¶¶ 214-15.) These allegations are clearly sufficient to support a claim under Section 1132(a)(1)(B). Indeed, Mr. Moorman's claim under that latter section is virtually identical.[20] The fact that Mr. Moorman did not succeed on his Section

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[20] The court notes that Mr. Moorman's Complaint incorporates the same paragraphs, 31 through 145, for both Count 12, wrongful denial of benefits pursuant to ERISA, and Count 13, breach of fiduciary duty pursuant to ERISA. (Compl. ¶¶ 206, 210.) This is not a case in which Mr. Moorman has conceded for purposes of his fiduciary duty claim that he is not entitled to benefits under the plan and proceeded in the alternative. *See Jones*, 370 F.3d at 1074. Rather, Mr. Moorman has asserted *exactly* the same facts and simply claimed another remedy. His entire case is premised on Unum's denial of benefits under the plan. He has a fully adequate remedy under Section 1132(a)(1)(B), and may not also pursue one under Section 1132(a)(3).

1132(a)(1)(B) claim does not change the result. *Ogden,* 348 F.3d at 1287 ("[T]he availability of relief under Section [1132](a)(3) was in no way dependent on the success or failure of the Section [1132](a)(1)(B) claim because 'the availability of an adequate remedy under the law for *Varity* purposes, does not mean, nor does it guarantee, an adjudication in one's favor.'") (*quoting Katz,* 197 F.3d at 1089).

Section 1132(a) (1)(B) clearly and unambiguously provided Mr. Moorman with an adequate remedy for his injury by allowing a cause of action to recover any benefits due to him under his plan. Therefore, he may not proceed under a Section 1132(a)(3) theory of recovery. *Ogden,* 348 F.3d at 1288. Unum's Motion for Summary Judgment as to Mr. Moorman's claim for breach of fiduciary duty is GRANTED.

C. Statutory Penalties under ERISA

Mr. Moorman requests statutory penalties for Unum's alleged failure to comply with 29 U.S.C. § 1132(c)(1). It is unclear whether Mr. Moorman is alleging that Unum failed to send him his own claim file, or that Unum failed to send him copies of claims manuals or other training materials, or both. (*See* Compl. ¶ 219; Pl.'s Resp. to Defs.' Mot. for Summ. J. 30-31.) Regardless of what precisely Mr. Moorman's allegations are, the court rejects his request for statutory penalties.

ERISA provides that a court *may,* in its discretion, hold a plan administrator personally liable to

a beneficiary for failure to comply with requests for information. 29 U.S.C. § 1132(c)(1). The court declines to so exercise its discretion in this case. The penalty under Section 1132 is in the nature of punitive damages, and the court sees no basis for punishing Unum in this case. *See Scott v. Suncoast Beverage Sales, Ltd.*, 295 F.3d 1223, 1232 (11th Cir. 2002). The record shows that Unum complied with Mr. Moorman's request for relevant documents in his claim file made on August 2, 2000.[21] Ms. Moorman requested his file in 2003 and Unum provided it again. The record does not reflect that Mr. Moorman made any other requests for documents.[22]

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[21] Mr. Moorman disputes this conclusion but offers no evidence in support of his position. Mr. Boothby testified that he sent a package of documents to Mr. Moorman's first lawyer, Mr. Farrar, on August 9, 2000. A notation indicating that he did so appears in the administrative record. (Administrative R. 159-60.) Mr. Moorman does nothing more than repeat the unsubstantiated allegation that Mr. Farrar, who is no longer a part of this case, never received the documents. That is insufficient to create a factual dispute.

[22] Indeed, it is totally unclear from Mr. Moorman's submissions to the court what portions of his claim file Mr. Moorman believes he requested yet did not receive. The court does not know what manuals or training materials Mr. Moorman would have desired to have Unum provide, and to what use he would have put them. Mr. Moorman has been far from diligent in pursuing his claim, appealing an adverse decision in 2000 yet failing to provide updated medical records despite repeated invitations to do so, and then allowing the case to lapse until 2003, when he again requested Unum to review its decision, *again* without updated medical records.

It is in any event impossible for the court to even hypothesize a way in which Mr. Moorman was prejudiced by Unum's alleged failure to provide documents. *See id.* ("[T]he Eleventh Circuit has stated that prejudice is a factor to be considered in determining the appropriate penalty."). Therefore, the court finds that statutory penalties are not appropriate. Unum's Motion for Summary Judgment on the claim for statutory penalties is GRANTED.

D. Federal RICO

Mr. Moorman alleges that Unum's "bad faith claims handling scheme" violated the federal RICO statute, 18 U.S.C. § 1961 et seq. (Compl. ¶ 186.) The racketeering activities that Unum allegedly committed are acts of mail and wire fraud, in violation of 18 U.S.C. §§ 1341 and 1343. *See* 18 U.S.C. § 1961(1).

Mail and wire fraud result from both a scheme to defraud, by way of false pretenses or representations, and the use of the mails or the wires, respectively, for the purpose of executing the scheme. *Neder v. United States,* 527 U.S. 1, 20 (1999); *Pereira v. United States,* 347 U.S. 1 (1954). To recover under any RICO claim, the plaintiff must show that his injury flowed directly from the predicate act. "[W]hen the alleged predicate act is mail or wire fraud, the plaintiff must have been a target of the scheme to defraud and must have relied to his detriment on misrepresentations made in furtherance of that scheme." *Pelletier v. Zweifel,* 921 F.2d 1465, 1499-1500 (11th Cir. 1991). Mr. Moorman

has identified no false pretenses, misrepresentations, or other fraudulent acts engaged in by Unum.

Mr. Moorman presents two theories of RICO predicate acts that Unum allegedly committed. In the first, Unum allegedly misrepresented that the WIBP program would apply to Mr. Moorman. Relying on that alleged misrepresentation, Mr. Moorman returned to work on a part time basis, and Unum then terminated his benefits, specifically referencing his return to work as a factor. Mr. Moorman has submitted only argument, and no credible evidence to support these allegations. Unum did tell Mr. Moorman that WIBP applied to his plan but subsequently withheld his benefits because it believed the program did not apply. Unum later corrected its error and refunded Mr. Moorman the payments he was due. Unum also referenced Mr. Moorman's return to work because, at the time he returned to work, he had been receiving long term disability payments for less than 12 months. The definition of disabled in the first 12 months of disability relates to one's ability to perform the duties of his regular occupation and the percentage of one's loss of monthly income. It was therefore entirely relevant and proper for Unum to have mentioned that Mr. Moorman had returned to work when it detailed his claim history.

In his second theory, Mr. Moorman asserts that Unum sent him letters representing that Unum was reviewing his appeal, when in fact it was not. The letters were allegedly calculated to cause Mr. Moorman to believe his medical file was complete when it

was not. This theory is contradicted by the record evidence. Unum sent Mr. Moorman numerous letters inviting him to submit additional evidence and notifying him that Unum had no updated medical records. There is also ample evidence to show that Unum did review Mr. Moorman's claim, and properly rejected it.

Mr. Moorman submitted a claim for disability benefts [sic], and Unum denied his claim. As has been extensively detailed in this Order, Unum did not *wrongfully* deny his claim, much less do so fraudulently. "[A] plaintiff only can show a scheme to defraud if he proves that some type of deceptive conduct occurred." *Id.* at 1500. Mr. Moorman has made no such showing. Accordingly, Unum's Motion for Summary Judgment on the federal RICO claim is GRANTED.

III. Conclusion

For the foregoing reasons, Defendant Unum's Motion for Summary Judgment [Doc. No. 110] is GRANTED as to all claims. This case is hereby DISMISSED.

IT IS SO ORDERED, this 4th day of March, 2008.

/s/ Beverly B. Martin
BEVERLY B. MARTIN
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

ROSS GLENN MOORMAN, JR.,

Plaintiff,

vs.

UNUMPROVIDENT CORPORATION, et al.,

Defendants.

CIVIL ACTION FILE

NO. 1:04-cv-2075-BBM

JUDGMENT

This action having come before the court, Honorable Beverly B. Martin, United States District Judge, for consideration of defendants' Motion for Summary Judgment, and the court having granted said motion, it is

Ordered and Adjudged that the plaintiff take nothing; that the defendants recover its costs of this action, and the action be, and the same hereby, is **dismissed**.

Dated at Atlanta, Georgia, this 4th day of March, 2008.

JAMES N. HATTEN
CLERK OF COURT

By: /s/ Emily Bulat
Deputy Clerk

Prepared, Filed, and Entered
in the Clerk's Office
March 4, 2008
James N. Hatten
Clerk of Court

By: /s/ Emily Bulat
Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

ROSS GLENN MOORMAN, JR.,

Plaintiff,

v.

UNUMPROVIDENT CORPORATION, et al.,

Defendants.

CIVIL ACTION FILE
NO. 1:04-CV-2075-BBM

ORDER

(Filed Feb. 4, 2008)

This matter is before the court on Plaintiff Ross Glenn Moorman, Jr.'s ("Mr. Moorman") Motion for Leave to File Cross-Motion for Summary Judgment [Doc. No. 128].

The deadline in this court for filing motions for summary judgment is no later than twenty days after the close of discovery, unless otherwise ordered by the court. LR 56.1D, N.D. Ga. Discovery in this case concluded on December 21, 2007. In its Order denying an extension of discovery [Doc. No. 107], the court specifically reminded the parties that motions for summary judgment were due on or before January 10, 2008. Mr. Moorman did not file a summary judgment motion by January 10, 2008, and now seeks permission to submit an untimely motion for summary judgment.

"[D]istrict courts enjoy broad discretion in deciding how best to manage the cases before them." *Chudasama v. Mazda Motor Corp.*, 123 F.3d 1353, 1366 (11th Cir. 1997). This case was originally filed on July 16, 2004, and has undergone a protracted discovery schedule. Mr. Moorman failed to file for summary judgment within the clearly delineated time limit set out by the court. The court further notes that Defendants Unum Life Insurance Company of America and UnumProvident Corporation filed a timely Motion for Summary Judgment, to which Mr. Moorman has responded. Mr. Moorman's proposed Brief in Support of his Cross-Motion for Summary Judgment does not raise any significant factual or legal arguments that are not already represented in his Response Brief. The court concludes that permitting Mr. Moorman to file an untimely summary judgment motion is not in the interests of judicial economy in this case.

Therefore, Mr. Moorman's Motion for Leave to File Cross-Motion for Summary Judgment [Doc. No. 128] is DENIED.

IT IS SO ORDERED, this 4th day of February, 2008.

/s/ Beverly B. Martin
BEVERLY B. MARTIN
UNITED STATES
DISTRICT JUDGE

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 08-11532-JJ

ROSS GLENN MOORMAN, JR.,

Plaintiff-Appellant,

versus

UNUMPROVIDENT CORPORATION,
a Delaware corporation, in its individual capacity and as controlling parent of its wholly owned subsidiary, Unum Life Insurance Company of America, a Maine corporation, UNUM LIFE INSURANCE COMPANY OF AMERICA, a Maine corporation, in its individual capacity and as a wholly owned and controlled subsidiary of UmumProvident [sic] Corporation, UNUM CORPORATION, a Maine corporation merged to form UnumProvident Corporation, in its individual capacity and as controlling parent company of its wholly owned subsidiary, Unum Life Insurance Company of America, A Maine corporation,

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of Georgia

ON PETITION(S) FOR REHEARING AND PETITION(S) FOR REHEARING EN BANC

(Filed Feb. 13, 2009)

Before: BIRCH and PRYOR, Circuit Judges, and STROM,* District Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no Judge in regular active service on the Court having requested that the Court be polled on rehearing en Banc (Rule 35, Federal Rules of Appellate Procedure), the Petition(s) for Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ William H. Pryor, Jr.
UNITED STATES CIRCUIT JUDGE

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* Honorable Lyle E. Strom, United States District Judge for the District of Nebraska, sitting by designation.